Exhibit 38

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION — MDL NO. 1456

THIS DOCUMENT RELATES TO: ALL CLASS ACTIONS — MASTER FILE NO. 01-CV-12257-PBS

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA IN AND FOR THE COUNTY OF MARICOPA

ROBERT J. SWANSTON, INDIVIDUALLY AND ON BEHALF OF HIMSELF AND ALL OTHERS SIMILARLY SITUATED — PLAINTIFF

VERSUS — NO. CV2002-004988

TAP PHARMACEUTICAL PRODUCTS, INC.; ET AL. — DEFENDANTS

****

DEPOSITION OF MICKEY BROWN

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APPEARANCES NOTED HEREIN
TAKEN AT INSTANCE OF: DEFENDANTS
DATE: MARCH 9th, 2005
PLACE: BRUNINI, GRANTHAM, GROWER & HEWES
POST OFFICE DRAWER 119
JACKSON, MISSISSIPPI 39205-0119
TIME: 10:00 a.m.

APPEARANCES:

FOR THE PLAINTIFFS
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FOR THE DEFENDANTS
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MICKEY BROWN,
after having first been duly sworn, was examined and testified under oath as follows, to-wit:

EXAMINATION

EXAMINATION BY MR. ROBBEN:

Q Good morning, Mr. Brown. My name is Philip Robben. I represent one of the defendants in this case, Dey, Inc., and I'm here to ask you some questions today. Have you ever given a deposition before?

A Yes.

Q How many times?

A Three.

Q Three times. About how -- do you remember the approximate dates of those examinations?

A I don't.

Q Okay.

A I did one within the last three or four months, and the others have been a couple of years

ago.

Q Okay. The one you did a few months ago, was that in connection with your employment?

A Yes.

Q Do you remember what the general nature of the case was?

A It had to do with code editing.

Q Okay.

A Procedure code editing.

Q Okay. And then the depositions before that, were they in connection with your employment?

A They were.

Q Okay. At the time were you employed by Blue Cross/Blue Shield of Mississippi?

A Yes, sir.

Q Okay. All right. As you probably remember from those -- but I'll just go over it just for the record. We're being recorded by a written record. There's a stenographer. We have to give a verbal response, and I have to ask verbal questions. She can't take down nods of the head and things like that, so I'd ask that you speak. I'll try not to

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interrupt you when you're giving your answer.
If at any time you don't understand a question I've asked, I'd ask that you let me know that so I can try and clarify it so that we can get the best possible answer.
Now, my understanding is that you're being produced today to give testimony on behalf of Blue Cross/Blue Shield of Mississippi; is that correct?
A Yes.
Q And do you understand that you're giving testimony on behalf of the company?
A Yes.
(DOCUMENT MARKED AS DEPOSITION Exhibit Brown 001 AND ATTACHED.)
MR. ROBBEN: (Continuing.)
Q Okay. Now, we've previously marked one exhibit which I'd like to show you. It's a February 4th, 2005 letter that I sent to your attorney, Mr. Donnell. And at the last two pages of the exhibit are a rider, and I'd just ask you to take a look at that and let me know if you've ever

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seen that letter before.
A I've not seen the letter portion, but I have seen the questions or the rider topics.
Q Okay. So you --
A But it had a different heading when I -- when I reviewed it.
Q Okay. Can you look through -- in the exhibit there, there are topics 1 through 25. Can you look through those and let me know whether you're prepared to testify as to all those topics today.
MR. DONNELL: Do you mean in your question does he have relative information on these topics, or is he prepared to just respond to questions regarding these topics?
MR. ROBBEN: Well, I mean, in the -- is he prepared to give testimony on those topics as a 30(b)(6) designee of the company?
A I don't understand what that -- what that means, what you just said, 30(b)(6). And I

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don't know if that's different than what our attorney just asked. I'm confused with now what the question is.
MR. DONNELL: I asked you, Philip, whether you were asking him if he had relevant information with regard to all of these topics. If your question is can he respond to all of these, I'd ask that you clarify that, whether it's 30(b)(6).
But if you are asking him whether he has information regarding each of these topics, I'd ask that you make that clarification as well.
MR. ROBBEN: (Continuing.)
Q Well, do you have relevant information as to each of the topics on this -- on this list?
A If you mean do I have knowledge and the ability to answer questions related to these, the answer is yes. If you mean do I have documentation with me, the answer is no.
Q Okay. Is there anybody that you're

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aware of that has -- or strike that.
Are you the most knowledgeable to testify as to these 25 topics?
A I'm as knowledgeable as anyone else.
Q Okay. Can you give testimony that reflects the knowledge of Blue Cross/Blue Shield of Mississippi as to these topics?
A Yes.
Q Okay. Can you give that testimony for -- well, what period of time can you give testimony on behalf of the company as to these topics?
A I have been employed with Blue Cross of Mississippi in total for 11 years. I was hired in 1991 and remained employed through 1996. I left Blue Cross and worked for other employers from late '96 to the middle of 1999, and have been employed in my current capacity since -- I believe it was July of 1999 to present. So I can provide my knowledge of those time periods.
Q Okay. For the period when you weren't with Blue Cross/Blue Shield of Mississippi, can

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you -- do you have any knowledge about the company's practices at that -- during that period of time?
A Yes, I do.
Q Okay. Did you do anything to prepare for today?
A I spoke with our external counsel and our internal legal staff.
Q Okay. How many -- about how many times did you speak to each of those?
A Three or four, somewhere around that. I don't believe it was more than that.
Q Okay. Did you review any documents?
A Just these -- these statements in this attachment to the letter.
Q Okay. So just the Exhibit 1?
A Yes. I'm sorry.
Q Just the rider?
A Just the rider to Exhibit 1, yes, sir.
Q Okay. Have you ever spoken to anybody representing the plaintiffs in this litigation, to your knowledge?
A Not that I'm aware of.

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Q Okay. I'd like to just ask you some questions about -- about your background. I assume you graduated from high school?
A Yes.
Q That's an easy one. Did you go on to any education after high school?
A I have a four-year college degree.
Q Okay. What college or university did you obtain that from?
A Millsaps College in Jackson, Mississippi.
Q What year did you graduate?
A I graduated in 1991.
Q Did you have a -- let me strike that. What's your degree?
A History. I have a BA in history.
Q Okay. When you were in college, did you take any courses that were related to the healthcare industry or healthcare in general?
A Not that I remember.
Q Okay. Fair enough. After graduating from college, what was your first employment?

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A I was employed by Blue Cross/Blue Shield of Mississippi as a health underwriter.
Q Okay. Was -- I should ask, were you employed during college?
A Yes.
Q Who was your employer then?
A I had various employers. I worked as a waiter in a restaurant, Perkins Family Restaurant. I worked as a runner in various law firms. I don't remember the names, and, in fact, I don't think many of them still are firms.
Q Okay. Well, how about this, were any of in the -- in the insurance or healthcare fields?
A I have no idea what their fields were. I just delivered the mail.
Q Oh, okay. I meant did your employers work in healthcare or in --
A I worked for a restaurant and for law firms, and I'm not sure what the law firms did. I just delivered the mail.
Q Fair enough. Okay.
A I also worked for a bank.

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Q Okay. So in 1991, you began at Blue Cross/Blue Shield of Mississippi as a -- you said it was a health underwriter?
A Health underwriter.
Q Okay. Now, how long did you hold that position?
A I don't remember the exact dates. I believe I did that for roughly two years.
Q Um-hum. Okay. And then what was your position after that?
A I worked as a network product coordinator.
Q Okay. And then how long did you hold that position?
A Around -- around eight months, six months, something like that. And then I was moved into a position called managed care coordinator.
Q Okay. How long did you hold that position?
A I did that until I left in October of 1996.
Q Okay. And then when you -- when you

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left Blue Cross/Blue Shield of Mississippi, where did you go after that?

A I went to a company called Diversified Services, Incorporated, which was a wholly-owned subsidiary of the Mississippi Hospital Association, as their director of managed care.

Q Okay. And how long did you hold that position?

A I did that for about 11 months, and then I went to a company called United Healthcare of Mississippi.

Q Okay.

A And I did that until I came back to Blue Cross in June or July of 1999.

Q Okay. What was your position with United Healthcare?

A I was the manager of hospital contracting.

Q Okay. Now, after you worked for United Health, did -- well, strike that.

Did you work as the manager of hospital contracting the entire time you were with them?

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A Yes.

Q Okay. Now, after that -- that time with United Healthcare, you returned to Blue Cross/Blue Shield?

A Yes. I returned to Blue Cross/Blue Shield, and my position was manager of the AHS state network.

Q Did you say HHS?

A AHS. A as in apple.

Q What does AHS stand for?

A AHS stands for Advanced Health Systems, which is a wholly-owned subsidiary of Blue Cross/Blue Shield of Mississippi, though I was technically a Blue Cross/Blue Shield of Mississippi employee.

Q Okay. And how long did you hold that position?

A I held that position for, I think, a year, and then I was promoted to the director of provider contracting. I'm sorry I don't have firm dates. I'm trying to recall some of these.

Q Okay.

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A There weren't formal transitions, but it was around a year that I did AHS state network, and then I was promoted to director of provider contracting, a position that -- well, my title recently changed in December of last year to director of provider networks, though I still have the same area of responsibility with -- with an additional area.

Q Okay. So you're currently director of provider networks?

A I'm currently director of provider networks. Although my business cards haven't changed, my job title has.

Q Okay. Now, if I can bring you back to your first job where you were a health underwriter, your first position at Blue Cross/Blue Shield. What were your responsibilities in that position?

A I evaluated the health risk of individual applicants for individual health insurance products to determine whether they were an acceptable health risk for a policy with Blue Cross.

Q Okay. Now -- then your job changed to

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network product coordinator. What were your responsibilities in that position?

A My responsibility was to develop managed care type insurance products, benefit plans, and provider networks to support those plans.

Q Um-hum. At that point did Blue Cross/Blue Shield have managed care plans, or did you work on the first plans that were developed?

A Well, I would really have to ask for your definition of managed care, because it really is a broad spectrum and -- to give you an accurate answer. What do you -- can you define what you mean by managed care? And then I can tell you whether we meet that -- met that criteria before I was in that position.

Q Right. I think we might come back to this.

A Okay.

Q So I'll -- I'll come back.

Now, your next position was managed care coordinator, what was your response -- what were your responsibilities in that position?

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A Similar to what I had as network product coordinator, but more focused on management of provider networks rather than benefit plans. As I was focused -- as the network product coordinator.

Q What was -- what is -- at that time what was the provider network?

A Provider network at that time would have been physicians and hospitals, certain what we call Allied health providers, would have been the bulk of our provider networks at that time.

Q Then you switched to diversified services and were director of managed care, correct?

A Yes.

Q What did you -- what were your responsibilities in that position?

A Diversified services had contracted with -- I believe it was 14 individual hospitals to create an insurance company, to manage an insurance company for them. And I was responsible for provider contracting and various managed care activities of that insurance company.

Ultimately, the insurance company was

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never successfully operated and acted more as a third-party administrator for self-insured plans. Had very little underwritten business, and it mainly functioned as third-party claims administrator. But that's what I was hired to do, was to do the provider contracting for those 14 hospitals.

Q Okay. Did it administer third-party claims at any time for Blue Cross/Blue Shield of Mississippi?

A Not that I'm aware of.

Q Okay. Okay. Then you came back to Blue Cross/Blue Shield, and you were manager of AHS state network?

A No. Actually, I went to United Healthcare as the manager of hospital contracting.

Q Correct. Sorry about that. What was your -- what were your duties in that position?

A To negotiate reimbursement contracts with participating hospitals for their hospital network. That also included ambulatory surgery centers and hospitals.

Q What type of a business was United

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Healthcare?

A It's a licensed HMO.

Q Okay. Then you returned to Blue Cross/Blue Shield of Mississippi?

A Correct.

Q And took the position as manager of AHS state network?

A Correct.

Q And what were your duties in that position?

A Advanced Health Systems had been contract -- had won a contract with the Mississippi State and School Employee Health Plan to develop and implement an exclusive preferred provider network for state and school employees. And my job was that development and implementation and ongoing management of all of the network activities. And it was exclusive to state and school employees for the State of Mississippi.

Q Okay. Then you moved into the director of provider contracting position?

A Correct.

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Q Now, what were your responsibilities in that role?

A Well, I retained the responsibilities in my previous position, but in addition, I became responsible for the provider contracting activities for Blue Cross/Blue Shield of Mississippi.

Q When you say provider contracting, that's -- well, how do you -- how do you define that?

A You mean the types of providers?

Q Yes.

A Physicians, hospitals, and Allied health providers.

Q What is an Allied health provider?

A It's a non-physician, non-hospital, provider. Like an ambulatory surgery center, a home infusion provider, a home health provider, durable medical health equipment provider. Those sorts of providers.

Q And now -- and now you're currently director of provider networks, correct?

A Correct.

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Q And how have your responsibilities changed from your last position to today?
A Well, I've retained all of my past responsibilities and have added responsibility for external provider services. We have a staff that travels around the state and service -- and provides service in office to the various providers in our networks and. Then I also have responsibility for our electronic claims and electronic provider remittance functions. We have a -- a call center that services those telephonically. I'm responsible for that area.
Q Okay. Now, in your -- in your current -- well, strike that.
During your prior positions -- or should I say in any of your positions, have you been responsible for pharmaceutical reimbursement?
A Yes. I have in former -- former positions. Depending on the type of provider, there would be pharmaceutical reimbursement involved.
Q Okay. Have you ever had any responsibility for reimbursement to pharmacies?

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A No direct responsibility for reimbursement to pharmacies.
Q So your prior responsibility would be reimbursement to physicians and those types of providers?
A Correct.
Q Okay. Now, have you had any -- any responsibility with contracting at any point with PPMs?
A No.
Q Okay. Now, during the course of your employment, have you ever heard the term "AWP"?
A Yes.
Q Okay. What's your understanding of AWP, what it means?
A What AWP stands for, the acronym stands for?
Q Well, I understand it stands for average wholesale price. Do you agree with that?
A I understand that the acronym AWP represents average wholesale price. Is that what you're asking me?

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Q Yes. But what -- what is your understanding of what -- what's your understanding of what the -- strike that.
What's your understanding of what it -- what it means in day-to-day usage?
MS. FEGAN: Object to the form.
MR. ROBBEN: (Continuing.)
Q You can answer.
A Well, what it means in day-to-day usage for Blue Cross/Blue Shield is it's a point of reference that we use in establishing reimbursement for drugs, pharmaceuticals. Now, is that -- I'm not -- I'm not -- still not sure that I'm clear on the question.
Q Well, do you understand it to be a -- a price that is -- that represents the cost of pharmaceuticals to any particular purchaser?
MS. FEGAN: Objection to form.
MR. ROBBEN: (Continuing.)
Q You can answer.
A Okay. I -- again, I think, you know, for purposes at Blue Cross, it's strictly a point of

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reference, what the actual cost of acquisition is. It's -- it's not -- it's not really something that we consider. We use it as a point of reference in establishing our reimbursement.
Q Okay. Is that your current -- when you say use as a point of reference, that's your current usage of it today?
A That's our current usage of it today, is as a point of reference.
Q Okay. Has your understanding of that term changed over time?
A No.
Q Okay. Do you have any -- do you subscribe or does Blue Cross/Blue Shield subscribe to any newsletters or industry publications that deal with -- with pharmaceutical pricing?
A We subscribe to numerous publications, and I'm sure that pharmaceutical pricing is addressed in those publications. Specifically on that topic, you know, I'm not a -- I'm not aware of if we do or if we don't.
Q Okay. Are you aware that there are

pricing compendia in the industry, such as First Data Bank and Red Book and others?

A Yes. We do -- now, if that's what you're asking, that's -- back to the original question. We do subscribe to Red Book.

Q Just -- just Red Book?

A Oh, I know that we get Red Book and that we have another AWP pricing that's loaded to our -- to our computer system, again, as a point of reference, but I'm not sure if it's First Data Bank or Red Book.

Q Okay. Now, do you know how long Blue Cross/Blue Shield has subscribed to those compendia?

A I have no idea.

Q Okay. Do you know how they decided which subscription to obtain?

A I have no idea.

Q And any --

A Nor do I think anybody else would recall. It's been -- we've had -- we've accessed those resources for many years, and I'm not sure if anyone would remember how the decision was arrived.

Q In the course of your work, do you have reason to refer to those publications?

A As I said before, we use it as a point of reference in our reimbursement decision-making, so I do have access and do use the information. But, again, as -- simply as a point of reference.

Q Okay. I'd like to ask you some questions about the type of products that Blue Cross/Blue Shield of Mississippi provides and some background on the company itself.

Do you know when the company was founded?

A 1949.

Q Okay. Now, what's your area of coverage in terms -- in other words, where do your -- where's your membership base?

A We cover the entire state of Mississippi.

Q Okay. Do you cover any persons or companies outside of that state?

A We may have members that reside outside of Mississippi, but they would be associated with an employer or maybe a dependent child of a resident of

Mississippi. We don't -- we don't sell products to groups or to individuals that reside outside of Mississippi.

Q Okay. So if I live in, say, Alabama but I work for a company in Mississippi, you might cover me, but it's only because my employer that bought the policy is a Mississippi company?

A Correct.

Q Okay. Now, do you -- does the -- does Mississippi Blue Cross/Blue Shield provide anything other than health insurance?

A We provide dental insurance and through a subsidiary company, we provide life insurance.

Q Do you know the name of that sub?

A Blue Bonnet. And we also provide third-party administration services, which in my mind, is different than health insurance. We're a claims administrator.

Q Okay. Do you know who those services are provided for?

A Various self-insured plans across Mississippi.

Q Do you have -- do you know the names of any of those self-insured plans?

MR. DONNELL: This is -- let me interject here. We're getting a little far afield of the deposition topic list, the rider. If we could steer back towards that, I would appreciate it.

MR. ROBBEN: Okay.

MR. ROBBEN: (Continuing.)

Q How many -- how many lives are covered by Blue Cross/Blue Shield of Mississippi's products?

A I -- I don't -- I would have to -- to guess. I'm not sure of the exact number.

Q Would you say it's more than a million?

A No.

Q Is it less than -- is it more than 500,000?

A My guess would be it's between 500,000 and a million, but exactly where, I don't know.

Q Fair enough. Now, can you give me -- can you tell me what types of health insurance plans you offer?

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A Do you mean the types of policies that we offer?
Q Yes.
A I am not an expert on benefit plans that we currently offer, but very generally we offer what we call a comprehensive plan and a -- a network plan, the difference being that one has an in and out of network differential. If you use the network provider, you get a higher benefit level. If you use a non-network provider, lower.
Whereas the comprehensive generally doesn't have those features in it. That would be the striking difference between the two. But beyond that, the subcategories of those, I'm not really familiar with how -- you know, the benefit details.
Q Okay. And the -- on -- where you have the network plan, are there networks of -- I assume there's networks of providers such as doctors?
A Yes.
Q Are there also pharmacy networks?
A Yes.
Q Do you know if Blue Cross/Blue Shield of

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Mississippi offers any type of what might be called an indemnity plan, a plan where a beneficiary would pay out of their own pocket for services and subscriptions and -- receive a check for reimbursement after the fact?
A Well, I'm not sure I'm clear on the question. Because any of our policies, that sort of transaction could happen. Can you --
Q Well, yes.
A Can you be more specific on an indemnity policy?
Q Are there any policies where that's the sole method of making a claim. In other words, there is no -- where the -- the claim is submitted by the beneficiary, and then the -- the benefits are paid directly to the beneficiary?
MS. FEGAN: Objection to the form.
A Are you asking are there benefit plans where the provider would never submit the claim?
MR. ROBBEN: (Continuing.)
Q Yes.
A I'm not aware of any, but, again, I'm

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not an expert on benefit plans.
Q Okay. Do you know if under the plans that are in place, your members pay any kind of coinsurance or copay?
A I know that they do, yes.
Q Do you know -- do you know if it's a -- have you ever heard the term "coinsurance"?
A Yes.
Q What's your understanding of that?
A My understanding of coinsurance is that the -- the plan pays a percentage, and the member pays a percentage. And the percentage that the member pays is their coinsurance.
Q Okay. As opposed to a copay?
A In our terminology, coinsurance is a percentage, and a copay is a fixed dollar amount.
Q So it's flat no matter what the cost of the underlying service or prescription would be?
A It's -- it's flat, but it might be tiered based on the service. I'll provide an example as a way to explain. A primary care physician may have a $15 copay, whereas a specialist

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physician is a $25 copay.
So it's a flat -- if you -- whatever primary care physician you use, it would be $15. And whatever specialist you use, it's $25, but it's not flat across the board no matter what type of physician you use.
Q Okay. Are there -- are there any Blue Cross/Blue Shield beneficiaries that pay based on a percentage of the cost of the services they -- they obtain? In other words, a coinsurance involved?
A Again, I'm not an expert on benefits, but there are -- I have Blue Cross insurance, so from my policy, I pay a coinsurance for certain services and a copay for other services.
Q Do you know whether -- well, let me back up.
I assume that the -- or let me ask you directly. Do the plans offered by Blue Cross/Blue Shield of Mississippi provide a prescription drug benefit?
A To the best of my knowledge, yes.
Q Okay. Do the beneficiaries of those

prescription drug benefits pay a coinsurance or a copay?

A I think it would depend on the plan. There -- there's probably a possibility that it's both, depending on what plan you have. One may be a copay; one may be a coinsurance. To the best of my knowledge, though, most of our plans have a copay, a fixed dollar amount.

Q Okay. Now, does Blue Cross/Blue Shield Mississippi own any of its -- own any pharmacies?

A Not that I'm aware of.

Q Do you have any doctor groups that you -- that you own? In other words, a group of doctors or a hospital that is owned by the plan?

MR. DONNELL: Again, we're getting a little bit far afield of the rider.

MR. ROBBEN: Well, I mean, I think that this is --

MR. DONNELL: Ownership of providers is nowhere found in the ridder that we agreed to submit a witness for.

MR. ROBBEN: Well, I think -- I

think that it goes to -- whether they own a hospital or a plan, I think, can affect how they reimburse for various services and their knowledge of reimbursements. So I'm really only getting into it as background.

MR. DONNELL: Okay. Again, if you want to ask about the methodologies for those providers, that's fine. Whether Blue Cross owns or has any interest in those is a little far afield. But I don't mind going through a little bit of background, which we've done to this point, but...

MR. MANGI: This is Adeel Mangi on the phone. I'll just add ownership of hospitals is also relevant -- directly relevant to the plan's knowledge of acquisition costs for drugs. So we would join counsel in submitting that the question is pertinent.

MR. ROBBEN: To the extent I ask

him about ownership of hospitals or physician groups or pharmacies, are you going to direct him not to answer?

MR. DONNELL: You know, if you limit -- limit it to that or get directly into the methodologies or how they -- their understanding of acquisition costs or acquisition price, average wholesale price, or whatever, that's fine. But limit it to those areas.

And I think you could craft your questions in a way that would satisfy that without getting into the private business of Blue Cross/Blue Shield. We're not putting Blue Cross/Blue Shield up today to explore their -- their ownership interests in other companies.

MR. ROBBEN: Well, I mean, to the extent your concern is confidentiality, we -- we have a strong and broad protective order in the case.

MR. DONNELL: Well --

MR. ROBBEN: And, you know, I'd be happy to -- you know, you can designate the whole -- the whole deposition highly confidential, and only attorneys are going to see it from that point forward and the Court.

MR. DONNELL: Well, that's still outside of our agreement. So, you know, if you could craft your questions to mold within this agreement, that's fine. But anything beyond that was not agreed to and should not be gotten into today.

MS. FEGAN: This is Beth Fegan. You know, I -- actually, I join in the witness's attorney's objections. I think we spent a lot of time on a lot of things that are very irrelevant and irrelevant to AWP and methodology for reimbursement and acquisition costs. So, you know, I think we can move along if we focus on those, and I think you'll

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end up getting the answers that you need.
MR. ROBBEN: All right.
MR. DONNELL: So, yes, to answer your earlier question, I will instruct him not to answer insofar as it goes beyond this topic list.
MR. ROBBEN: All right. Well, how about this?
MR. ROBBEN: (Continuing.)
Q Are you aware of the methodologies that Blue Cross/Blue Shield of Mississippi has used to reimburse for doctor-administered pharmaceuticals from 1991 to the present time?
A Yes.
Q Okay. What is that methodology? Or let me -- let me -- strike that.
Has that methodology changed over time?
A Reimbursement for injectable drugs can change annually. So the methodology has probably stayed roughly the same, but the reimbursement itself changes -- can change annually. Or it can

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actually change as needed throughout the course of an individual year.
Q Can the methodology be reduced to a -- to a formula?
A No.
Q How -- how is the -- what is the methodology? Is it -- for example, is it linked to AWP? Is it linked to some other benchmark or --
MS. FEGAN: Objection to form.
MR. ROBBEN: (Continuing.)
Q You can answer.
A Okay. Again, we use -- as I said in the earlier part of the deposition, we use AWP as a reference point. Reimbursement is established based on -- based on our needs as a company to present fair and reasonable reimbursement to the provider community and fair and reasonable reimbursement to Blue Cross/Blue Shield of Mississippi and our subscribers.
We do use AWP as a point of reference. We -- we reimburse for physician-administered pharmaceuticals, in the physician's office using the

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various HCPC codes assigned to the type of service they provide. You know, a HCPC code, a J code, and I believe a G code -- there's a few other types of HCPC codes -- can have multiple drugs assigned to that -- to that -- to that J code or other HCPC code.
And -- and we will choose either -- we'll choose the lesser of the lowest-priced brand using AWP for the -- to determine that or the low -- or the median generic, whichever is less. And then we apply some -- either a markup or markdown, just depending on our business need, to produce fair reimbursement to the folks I mentioned earlier.
So it's -- it's used in the calculation as a point of reference, a starting point for us to develop what we think is fair to the physician community, to Blue Cross to our subscribers.
Q Okay. Let me -- let me back up a little bit, because I think you said a lot of things there, and I want to understand it correctly.
Now, am I correct that when you -- that doctors submit their claims for drugs that they

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administer by J code?
A Or other HCPC code. There are other HCPC codes that --
Q That might take in --
A That might take into account an injectable drug or a physician-administered drug.
Q Okay. Now, when you get that claim in with that code, what's your next step?
A We have a set allowance for that particular HCPC code. We apply that allowance to the claim, then apply the subscriber's benefits, and we process the claim. Now, the -- the technical of how that flows, I'm not -- definitely not an expert in that area, but that's generally how it works.
Q Okay. How do you --
A So we have an established allowance for that.
Q Okay. How do you establish that allowance amount?
A We take the -- using the J code and a crosswalk to the NDC number for all of the drugs that -- that tie to that J code, we take the median

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generic or the lowest brand, whichever is less, and then we apply either a markup or a markdown, just depending on -- again, back to fair and reasonable reimbursement and what's acceptable in our marketplace.

Q Okay. Now, when you say you take the lowest brand of the median generic, you're talking about the lowest brand or median generic's AWP?

A Correct.

Q Now -- now, what's your source for the AWP?

A I believe it's Red Book.

Q Okay. Now, when you're dealing with generics, where do you find the median generic price?

A Every -- every NDC number ties to a J code in that range of drugs. So we take the average wholesale price for all of those national drug code numbers, and we determine the median internally.

Q So it's something you do in-house?

A Correct.

Q Okay. So, for example, I know, just

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from my own work, that albuterol sulphate is a -- is a drug made by a number of manufacturers. So if you have a claim for that drug, that J code that deals with albuterol sulphate, correct me if I'm wrong, in-house, you'll find all the applicable AWPs, and you'll take the median AWP; and that's the reimbursement benchmark?

MS. FEGAN: Objection to form.

A No. That's -- that's -- it's not on a claim-by-claim basis. We do an annual update to our professional reimbursement schedule, which includes the HCPC codes. So once a year we go in, and we calculate our standard allowance for the particular HCPCS code.

So it doesn't -- it's is not on a claim-by-claim basis. We -- we do an annual adjustment. We will -- we will periodically make adjustments to individual codes based on market concerns. But there's no quarterly, monthly, or claim-by-claim adjustment that's made.

We do an annual update. We do an -- excuse me. We do an annual review. There may not

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even be an update each year to mean change. We review it annually and determine is it still fair and reasonable to Blue Cross, to the provider, and to our subscribers. And if it is, we'll leave it alone. If it's not, we make adjustments.

MR. ROBBEN: (Continuing.)

Q Okay. So the amount that you're reimbursing, other than when you've updated your database won't change from claim to claim for the same J code or other code?

A Correct.

Q Okay.

A Unless we make an adjustment to that fee schedule mid year.

Q Okay.

A You know, based on -- on market need.

Q Okay. Now, what might -- what would be the type of event or concern that would cause you to readdress an individual code?

A You know, the standard concern would be communication back from our -- our provider partners that -- concern that reimbursement is low for a

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particular drug or on the rare occasion that it's high for a particular drug. And then we do some investigation from that point to -- again, back to fair and reasonable, or is it fair and reasonable, the price that we've established? If the answer to that is no, then we'll make an adjustment.

Q Okay. Can you think of any -- just sitting here, can you think of any particular codes that have been revised due to that market concern, I think you referred to?

A I can't. I mean, I don't remember any particulars, and I'm not -- I'm not even really familiar with the drug names that correspond to the -- to the J code. You know, I look at it at the J code level and not the individual drug names.

Q Uh-huh.

A So I'm not -- I don't recall. I mean, I know that we've done it, but I don't remember a particular code that we've changed. But I -- you know, I know that we do it.

Q Okay. Now, you said occasionally there'll be some information you'll receive that --

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that a reimbursement is too low.
How frequently, in your experience, has that happened?
A I would say it's infrequent. I mean, it's occasional. It's not once a month. It's not -- you know, it's not consistent. It's just -- it's very infrequent. And I don't have a way -- a better way to describe it. It's -- it's as needed, and it's very infrequent.
Q Okay. Now, you said that once you obtained either the -- once you -- you have in your system this lowest brand name or median generic, and then you -- I think you said that you either add or subtract to that figure.
What is the amount that you either add or subtract?
A That -- that varies depending on what we -- our corporate needs and what we think is fair and reasonable for the provider community. And it's just driven by -- driven by the market.
Q Does that amount vary by code?
A Generally, it does not. It's generally

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across the board. It doesn't -- I mean, we don't -- we don't look at it at the code level detail. We don't -- we're not -- we deal more big picture fee schedule reimbursement, not the individual -- you know, detail analysis of each individual code. And, you know, because of our experience and our marketplace and our close relationship with the provider community, we have an understanding of what we think is fair and reasonable, and we set that number there. That number can change year to year, but it's not a standard plus or minus.
Q Okay. Now, you said that the -- that the -- the -- if I can call it the AWP side of this reimbursement methodology is updated on the -- some basis. I think you said yearly basis?
A No. The fee schedule is reviewed annually, and -- and has the opportunity to be updated annually. The AWP side of that -- you know, the -- we get updates -- I guess it's quarterly -- to the system that says, Here's the new AWPs.
We don't go back and evaluate those on a professional fee side quarterly to see what the

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difference is. We -- we set it annually. And at the end of that year, we go back and evaluate again. So it's not -- the AWPs continue to change, is my understanding. But we don't go back and apply those back to the fee schedule continually.
We -- we establish an amount for each individual HCPC code, and it stays that amount unless someone alerts us to some issue with that price. We do an evaluation, and we may make an adjustment to that individual code. But it wouldn't be based on changes to AWP.
Q Now, the amount that you -- that you add or subtract from the code -- from the AWP that you get from the code, is that modifying amount changed on any regular -- regular basis?
A It's not changed on a regular basis. It's, again, back to our expertise and close relationship with our provider partners to understand what's fair and reasonable to that adjustment. And it's not -- it's not necessarily changed annually.
Q Now, does that -- does the reimbursement

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that's provided under your fee schedule, does -- is that the same for all providers, or can it vary from provider to provider?
A It's -- it's the same for all professional providers: Physicians, nurse practitioners, those types of providers that provide injectable drugs. Hospitals are reimbursed under a different reimbursement model. Home infusion providers have a different reimbursement model.
Q Okay. So all -- all physicians, all doctors --
A All doctors.
Q -- will receive the same reimbursement at the same -- for the same drug during the same period?
A For the same HCPC code, they'll receive the same price, same allowable.
Q Okay.
A Now, again, you have to apply benefits to actually calculate payment on a claim. And that may vary by patient depending on what their benefits are. But what is allowed for that particular HCPC

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code would be the same regardless of specialty or geography for the providers that -- in Mississippi.

Q Now, are there any types of -- of physicians -- let's say specialists -- that obtain a different reimbursement than another physician?

A Could you clarify that -- what you mean by that question?

Q Well, is there -- is there any type of provider -- well, strike that. Strike that.

Now, you did say that there could be variations between different types of providers. Hospitals, I think you gave as an example.

A What I said is there are different reimbursement models.

Q Okay. What's the reimbursement model for a hospital?

A Hospitals are paid -- we have -- we have a few different types of models. We have a DRG model. We have a per diem model. And then for the very, very small hospitals, typically less than ten admissions a year, we have a percentage of charge model. And all of that is for inpatient.

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On the outpatient side, we have what's called APG, and then we have percentage of charge, again, for the very small hospitals.

DRG and APG are similar models, although, technically different in what they -- but the reason that they're similar is that they -- they group all of the services on the claim to create a package price for that claim. So it basically groups an encounter, and it doesn't pay on an individual line level, but packages a price for that claim.

So, obviously, on discount from charge, that's based on what the provider charges us. We discount that and pay that amount. Again, very small hospitals, probably less than 2 percent of the actual dollars that come in the door are paid that way, inpatient and outpatient.

Inpatient, probably 90 percent of the dollars that we pay go to hospitals under the DRG model. The other 10 percent would go to -- or probably 8 percent would go to per diem hospitals, and, again, 2 or so on percentage of charge hospitals.

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But they're basically fixed reimbursement systems that pay package provides for services that are provided. So they don't pay this code equals this amount. It's this code in combination with all the other services that you do are packaged to create a price.

So it's not an individual line item like a professional claim is. Not an individual line item, J blank equals this. J blank equals that. It's outpatient chemotherapy is this package price, and it goes out that way.

Q Okay. So is it fair to say under those models, there is no specific reimbursement for any specific drug dispensed to that patient during that encounter?

A There's no specific reimbursement for a specific drug. The only situation where the drug is actually -- comes into play is if a claim is appealed for an exceptional circumstance because of the way it groups it. It's an averaging system. And there's always the opportunity for someone to be well outside of the average, and we -- we will

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adjust claims on appeal using AWP as a point of reference, again, for reimbursement.

But that's -- that's probably less than 2 percent of all claims. I know it's less than 2 -- less than 1 percent of all claims are appealed in that manner. But the standard reimbursement model does not pay a set reimbursement for a particular drug. It's a package price for an encounter.

Q Okay. So the -- is it fair to say, then, in addition, that because you're paying a package price, the AWP of the drugs administered during that encounter is irrelevant to the amount that you pay?

A I think that's fair to say, yes.

Q Now, are there any other types of providers other than the professionals and the hospitals? What other types of providers are there?

A You have home infusion providers, home health providers, ambulatory surgery centers, durable medical equipment providers, chiropractors, physical therapists, optometrists, dentists. While we don't contract with them, we do pay claims for

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dentists. I mean, on down the line, you know, who's licensed to provide healthcare services. I mean, we pay claims on those.

Q Now, are -- is the -- is the methodology for reimbursement different for each of these different types of providers?

A Professional Allied providers like chiropractors, nurse practitioners, physical therapists, the reimbursement models are the same. They actually are reimbursed off the fee schedule as physicians.

Ambulatory surgery centers is -- is a package pricing system. It doesn't reimburse separately for pharmaceuticals provided during the ambulatory surgery stay. It's based on what surgical procedure is performed. You get a package price for the surgical procedures that you perform.

Home health companies get a set amount per day to visit patients. Home infusion companies get a set amount per day, but they're also reimbursed separately for the drugs they provide based on the -- the J code that they submit.

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Q When they're reimbursed based on the J code that they submit, is the reimbursement similar to the reimbursement of a physician for a J code that they submit?

A It's -- it is different in that physicians are updated once a year unless there's an individual code that's adjusted. Home infusion companies actually price using the updates of the AWP. They're paid for the actual drug they provide; whereas, physicians are reimbursed for the J code they provide.

So it's a different system, but it's -- again, I have to go back to fair and reasonable. We establish the reimbursement rate to what we think is fair and reasonable to the physician, to Blue Cross, and to the patient. So in -- in the philosophy, it's the same. The structure and functionality may be slightly different.

Q Now, did you -- did you mention durable medical equipment providers?

A I did.

Q How -- remind me, how are they reimbursed?

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A They're reimbursed on a fee schedule, the same fee schedule that physicians are reimbursed on. I'm not aware of any pharmaceuticals that they provide. It's typically canes, crutches, wheelchairs, commode seats.

Q Okay.

A That sort of thing.

Q Okay. Now, you mentioned a number of times that fair and reasonable is, I guess, what you're trying to achieve. Is that fair to say?

A That is fair to say, yes.

Q Okay. What are the factors that you look at when you're trying to achieve whether you've obtained a fair and reasonable amount?

A Well, we have -- we have a very close relationship with our providers in the marketplace. We have -- we have numerous committees that -- while not related to reimbursement, are related to other functions.

We have an office manager's committee that looks at administrative efficiencies, what

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is -- how can we be better partners for them administratively. And -- and through all that intelligence, we -- in our 50-plus years of experience in this market selling health insurance, we have, you know, a fair amount of intelligence of what is acceptable in the marketplace, and that's -- that's a very good barometer for us of what's fair and reasonable.

Because we have these close relationships, the committees that we've created that -- that really provide input opportunities for physicians. And, again, while they're not fee schedule committees, they clearly have our ear when they're here to help us with other topics. We use those as barometers for what's fair.

Again, we've been in this market 50 years, so we've -- and we've had provider contracts, oh, since some point in the '80s of varying types. We have a very good feel for it. And then, you know, there's always feedback that you get from the provider community that we take into account. But just generally, our experience and understanding of

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our marketplace helps us to gauge what's fair.
Q Well, what type of feedback do you -- do you get?
A Well, generally it's positive, thus the good relationships that we have. But the sort of feedback that we would get is generally very, very candid. And I can't perform that service for at or less what you pay me for it. It would be general, and we would have very open discussions around those topics to get more to the matter of the issue.
I mean, we -- we have those discussions. We have -- as I mentioned before, I have representatives that travel around the state and service physicians in their office. So they're there, and that's an opportunity for feedback.
We have corporate medical advisor that runs our physician committees who until recently was a practicing physician. He's obviously a good opportunity for physicians to provide candid feedback.
And we -- and we really seek that feedback. We don't -- we don't -- we try and make

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it easy for our providers in the community to communicate with us their concerns, and we work with them to -- to try and resolve those. So it's -- it's very much an open give and take to get to that.
And I'll go back to those good provider partnerships that we have. We -- we expend a lot of effort to produce positive relationships with the provider community.
Q Is -- strike that.
Well, how do you -- how is the -- what is the process of contracting with providers like -- I mean, do you -- do they make a presentation or do they -- do they -- do you submit RFPs to them? Do they submit them to you? How do you -- how do you sign up providers for your -- for your network?
A Well, we've had a physician network since 1987, '88, around that time. And, you know, so the development period is a lot different. There were a lot more on-site meetings and discussions. The current process is very routine and almost an automated process.
We have one statewide fee schedule. We

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don't -- we don't individually negotiate fee schedules with individual physician practices. So there's not a sit-down -- there's no RFP. If a physician is new to the community or -- that's generally what happens. Or for whatever reason isn't currently participating and wants to begin participating, they call and request an application. They fill out an application. We credential them based on our criteria for participation, and they're either approved or rejected.
There's no sit-down with each individual physician. And we have -- the majority of the physicians in Mississippi participate, so we don't have to do a lot of active recruiting. So it's just a very routine process. We don't sit down and individually negotiate fees.
If we determine through these relationships that we have an issue with reimbursement on a particular code, if we make an adjustment, the adjustment is made for everybody, not just the one individual practice. That's -- to us, that's back to trying to be fair and reasonable.

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Q Uh-huh. (Affirmative response.)
A If -- if there's something that's -- that needs to be adjusted in our schedule, it's adjusted for everybody without -- without a formal request from them.
Q Does -- and this goes back somewhat to your prior testimony. When you're setting your -- your fee schedule for pharmaceutical products, does the -- does Medicare's fee schedule play any part in your thinking?
A Well, we're certainly aware of what Medicare is doing. And, again, it provides another point of reference, but it is not -- we don't set our prices based on what Medicare does.
You know, we like to be aware of what's going on in the healthcare marketplace, so, obviously, we would monitor what they're doing. But we don't -- we don't factor in what their reimbursement -- we don't -- we don't use their reimbursement to establish ours. We just have an awareness of what they're doing.
Q Is there any drug or are there any

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physicians that get paid an administration fee in addition to the drug reimbursement?
A I'm not sure I understand your question.
Q Well, is there any -- other than the -- well, strike that.
If a -- let's say a physician submits a claim for a drug administered to a patient, do they get the drug reimbursement alone, or do they get the drug reimbursement and also an additional fee for administering the drug?
A That would depend on CPT coding guidelines. We follow the CPT coding rules for that. And there is an opportunity to be paid an administration fee in addition to the drug reimbursement, but it all depends on CPT coding rules in that area, which I am not an -- necessarily an expert on CPT coding rules. But it would all depend on that, but there is that opportunity as long as it complies with those rules.
Q Have you ever had a provider just decline to participate in your -- in your network or to contract with you because they thought that the

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reimbursement rates were too low?
A I'm sure that we have.
Q When you're setting the reimbursement rate, does the -- do geographic considerations ever play into that -- into what you consider to be fair and reasonable?
A We have one statewide fee schedule. So it's -- it's not really feasible to make geographic adjustments inside the state of Mississippi. So they're not generally considered.
Q Okay. Does -- does Blue Cross/Blue Shield of Mississippi have competitors in the state?
A I don't market products, so I'm not sure. I know that we have competitors, but who they are, I don't know.
Q In -- in determining what fair and reasonable reimbursement is, is what other insurers might pay a consideration?
A Well, we don't have access to the information on what they pay. You know, so it doesn't -- it doesn't factor in directly. I mean, I don't have -- I know that United Healthcare is a

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competitor because I used to work for them, but beyond that, I don't know the names of the companies that are out there. And we don't have access to their fee schedules, so it would not be directly involved in establishment of our fee schedule. In fact, our fee schedule is developed independent of what they're doing.
Q Do you -- is -- is determining the fee schedule and the fair and reasonable nature of it -- do you ever use any outside consultant, or do you just rely on in-house people for all of that?
A We rely on in-house staff for that.
Q Now, has there been any -- any effort over time to lower reimbursement for -- for pharmaceutical products?
A We adjusted our pharmaceutical reimbursement last year. And for the most part, reimbursement was decreased, but it's not been a long-standing effort to drive those down.
Q Okay. So that's not part of a general strategy or plan to keep driving those reimbursements lower?

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A No. The strategy would be to evaluate annually to make decisions, you know, based on our latest intelligence from the marketplace, and that's what -- why the -- how the decision was made then.
Q Now, in setting the rate, the fair and reasonable -- in going through your fair and reasonable analysis, do you take into account what the providers are able to obtain the products -- what price they're able to acquire those at?
MS. FEGAN: Could you repeat the question, please?
MR. ROBBEN: Could you read it back?
(Previous question read back by the court reporter.)
MS. FEGAN: Objection to form.
MR. ROBBEN: (Continuing.)
Q Do you understand my question?
A Could you rephrase it?
Q Sure.
A Make sure I'm clear.
Q Well, when you're -- when you're

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deciding what you're going to reimburse pharmaceuticals at, does the provider's acquisition cost for that pharmaceutical play into that analysis?

A Well, we don't know their acquisition cost, and further complicating it is that multiple drugs tie to a single J code or HCPC code. So, you know, first, we don't know what they've acquired the drug for, but we really don't even know, because of the coding system in place, what drug they've actually provided.

You may have ten drugs that tie to one J code, and they're going to provide one of those ten and file it using the one corresponding J code. But we don't know which of those ten they actually administered, other than it's in this category that ties to the J code.

So when we do our analysis, we're looking at the actual HCPC code that comes in. We don't -- we don't acquire the NDC number on the HCPC claim form. So we wouldn't know which drug they actually administer, other than that it falls into the

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category tied to that J code.

Q Have you ever considered looking into what provider acquisition costs are?

A I don't know that it's ever been considered by Blue Cross. I mean, that would seem to be a much bigger effort than we're willing to undertake.

Q Is there -- well, strike that.

Is the -- is the cost that they're able to obtain the drug at relevant at all to your -- to your setting the reimbursement amount?

A It's not relevant doing our annual update. It would become relevant if we receive numerous inquiries from the physician community saying, I can't acquire the drug for at or above what your -- or at or below what you're paying for it.

And that's a concern to us. We're -- we're not in this business to -- to ask providers to provide healthcare at their own cost or free. We -- you know, we understand that providers are -- particularly professional providers are there to

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make a living, and we don't -- we don't have any qualms with that.

So if we're provided information that shows that the actual cost of the drug is more than what we've set for the allowance, then we -- we'll consider an adjustment at that point. Now, again, there are multiple NDC numbers that tie to one J code, so that has to be factored in.

They could be buying the most expensive drug out of the list of ten that are available to that corresponding J code. All of that's factored in, and we'll -- we share that information back of how our allowance -- you know, what -- where the reference point was for establishing that allowance.

And so there's definitely some give and take there. But as far as the annual update process, we don't -- we don't have the knowledge of what the actual acquisition cost is for that particular J code at this point.

Q Do you think it would be administratively feasible to obtain that acquisition cost?

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A It would not -- I'll have to speak in -- for my opinion here. I don't see that it would be feasible to survey the physician community in Mississippi to determine the acquisition cost for each drug. I mean, from -- with current staffing levels, without a lot of expense on our part, I don't think it's feasible.

Q Okay. Do you know how many doctors you contract with in Mississippi -- or providers, let's say?

A I'll have to give you a rough estimate. I would say around 4,000.

Q Does that include all sorts of specialists and -- as well as general practitioners and your other non-doctor providers?

A No. That includes just physicians.

Q Just physicians?

A If you add non-physician providers, I mean, the total panel is probably close to 8 or 9,000 of all -- excluding pharmacies, all providers. You know, pharmacies add to that number significantly because of chains and things that are

contracting.
Q Do you think it's fair to say if you had more knowledge about acquisition costs, it wouldn't -- it wouldn't necessarily lower your reimbursement?
MS. FEGAN: Objection to form. I don't know what you're talking about in terms of more information.
MR. ROBBEN: (Continuing.)
Q You can answer. If you understand, you can answer.
A Well --
Q Well, here, I'll rephrase it. I'm sorry.
If you had more information about provider acquisition costs, do you think it would have any effect on your reimbursement level?
MS. FEGAN: Same objection.
A Well, I can say that, again, our goal would be fair and reasonable reimbursement. I don't know if -- I don't have any information on the actual acquisition cost to know how it would affect

our reimbursement or how our reimbursement compares. But our end goal would be fair and reasonable reimbursement to the -- to the provider community.
It would -- again, it would probably just be another point of reference. You know, you would have just an additional point of reference to ensure that what we're doing is fair and reasonable. What the end result is, I have no idea.
MR. ROBBEN: (Continuing.)
Q Okay. By the way, if you want a break, just let me know, and we'll take a break at any point.
A Okay.
MR. ROBBEN: Okay. We're going to take a five-minute break.
(Off the record.)
MR. ROBBEN: (Continuing.)
Q Now, from what I hear you say, Blue Cross/Blue Shield of Mississippi has used AWP as a point of reference in its reimbursement.
Have you ever considered using a different point of reference?

A I'm not sure what other point of reference would be available, but not -- not that I'm aware of.
Q Okay. Switch gears a little bit. Now, does Blue Cross/Blue Shield of Mississippi have a relationship or a contract with any PBM?
A We're our own PBM.
Q Your own. Do you have an internal PBM?
A We have an internal pharmacy staff that operates our PBM.
Q Okay. How long have you used that? How long has that internal staff been performing that function?
A Oh, it would strictly be a guess on my part. I'm not sure how long that's been. It's been since my employment with Blue Cross.
Q Okay. What's their -- what is the pharmacy staff's role?
A Their role is contracting with pharmacies for reimbursement. But then they're also integral part of our medical management and disease management team involved in those sorts of programs.

MR. ROBBEN: Could you read that back?
(Whereupon, the question was read back by the court reporter.)
MR. ROBBEN: (Continuing.)
Q Do they create -- does that pharmacy staff create or maintain a formula?
A We have a formulary that they're involved in the development of. We also have a pharmacy and therapeutics committee that oversees that process.
Q Who are the members of the pharmacy and therapeutic committee?
A I don't know who they are. It would be practicing physicians, but I don't know any of their names.
Q Okay. And do you know the structure of the formulary?
A Could you clarify what you're asking?
Q Well, is it a tiered -- do you have several tiers of drugs on the formulary, or is it just, you know, one size fits all? How does it

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work?
A Well, it's -- it's a preferred and non-preferred list. I'm not sure what you mean by tiered.
Q Well, is there a -- is there -- when you say preferred and non-preferred, is there a different responsibility on the part of the member for drugs that fall into one of those categories.
MS. FEGAN: Objection to form.
A As I -- as I mentioned before, I'm not a benefit expert, but my understanding is that there would be different copay amounts for preferred and non-preferred.
MR. ROBBEN: (Continuing.)
Q Okay.
A And actually a different copay amount for generic drugs.
Q Okay. Would the generic copay be the lowest?
A Typically.
Q Do you know what factors go into the creation of that formulary?

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A The pharmacy and therapeutics committee assigns preferred and non-preferred and the clinical effectiveness of the drug. If a drug is, you know, a single source type of drug -- no other drugs are available -- then I think the final consideration is price of the drug. If -- all things being equal, if one drug costs more than the other, the lower price drug would be in the preferred category versus non-preferred.
Q Does Blue Cross/Blue Shield of Mississippi obtain rebates from pharmaceutical manufacturers?
MR. DONNELL: I'm going to object to that because that's outside of the scope of our agreement.
MR. ROBBEN: Well, I think whether they obtain rebates is directly tied to how they reimburse for the drugs, particularly in how they put together a formulary. So I think it -- I think it relates directly to reimbursement.
MR. DONNELL: Tie that to one of

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the agreed-upon topics.
MR. ROBBEN: Well, one, two.
MR. DONNELL: If you ask him whether any rebates were -- are used in considering the establishment of any methodologies, that might be a question, but I just -- it's a little bit far afield.
MR. ROBBEN: (Continuing.)
Q Well, in putting together the formulary, was the -- was the payment of rebates by pharmaceutical manufacturers a factor that was considered?
MS. FEGAN: Objection. Calls for speculation.
A I don't sit on the pharmacy and therapeutics committee, so I'm not -- I'm not certain how that -- that factors in. I know price of the drug is a consideration, but I'm not sure whether rebates are involved in that or not.
MR. ROBBEN: (Continuing.)
Q Okay.

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MR. DONNELL: Are you asking about rebates that pharmacies get?
MR. ROBBEN: No. Right now I'm asking about rebates that the plan gets.
MR. DONNELL: Okay.
MR. ROBBEN: (Continuing.)
Q So does Blue Cross/Blue Shield of Mississippi directly contract with retail pharmacies?
A Yes. Let me -- can I -- let me change that answer a little bit.
Q Sure.
A There are subsidiary company events, health systems, we contract with retail pharmacies.
Q Okay. Are those contracts entered into to provide a network for the -- for the beneficiaries of Blue Cross/Blue Shield Mississippi's members?
A I don't know what you mean by beneficiaries. If you mean plan participants --
Q Right.
A -- or members of our insurance products,

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then the answer is yes.
Q Okay. Now, how -- how do you go about recruiting pharmacies to join or to contract with Blue Cross/Blue Shield?
A Well, like the physician network, the network has been established for many years. I don't know how long. So currently it's -- it's just an administrative process. We get a call from a pharmacy to request an application. We send them the application. They sign an agreement, and then they're in the network. There's not -- we don't actually actively recruit for that network any -- anymore.
Q Okay.
A It's not a closed network, but we don't actively recruit it.
Q Now, do you have any understanding of where retail pharmacies obtain the products that they sell, the pharmaceutical products that they sell?
A No.
Q Do you have any understanding of the

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basis on which those products are priced when they acquire them?
A No.
Q Okay. Now, can you tell me about the methodology by which Blue Cross/Blue Shield of Mississippi reimburses pharmacies for dispensed pharmaceuticals?
A We -- they submit the NDC number for the drug. We determine the average wholesale price, and then we discount that based on contract negotiations with the pharmacy at various rates. And then they also get a dispensing fee that's negotiated with the individual pharmacies.
Q Okay. Now, is the -- is the discount from AWP a standard discount that applies to every pharmacy, or is that individually negotiated?
A Well, we have a standard discount, but we may, based on market need, make an adjustment depending on who the pharmacy is.
Q Do you know what the standard amount is?
A I don't.
Q Okay. Has that changed over time, the

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standard amount I'm talking about?
A Oh, it's -- it's -- it changed at some point in the mid '90s, but it's been pretty well consistent throughout. And I don't know whether it went up or down. I just know that it changed.
Q Okay. Has this methodology been in place since the mid '90s?
A Well, let me -- let me step back because I left out one component of that. Generic drugs are paid based on a fee schedule versus AWP that we acquire. My understanding is it's one that's developed by CMS. And we acquire that. It's called a maximum allowable charge schedule, MAC. And we use the MAC to price generic drugs.
I'm not sure what CMS uses it for, but they compile it; and we purchase it through some vendor. Brand drugs are paid based on the AWP minus a percentage. And I'm not sure how long that methodology has -- has been in place or if there were any significant changes in the mid '90s to how it worked.
Q Okay. Now, is there -- now, let me make

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sure I understand this. For generics, you use the CMS MAC schedule?
A Correct.
Q And, now, do you pay a dispensing fee in connection with generics?
A I believe we do.
Q Okay. Do you know -- in either case, brands or generics, do you know what the dispensing fee is?
A Again, it can vary by facility, and I don't know what the standard is.
Q Okay. So that's a -- is that a negotiated term?
A Insomuch as if we had to negotiate it, it would be a negotiable term.
Q Now, in negotiating that either discount off of AWP or the dispensing fee, what are the factors that go into that negotiation?
A The exact same factors that go into any of our reimbursement, the fair and reasonableness of the reimbursement.
You know, there's -- just our experience

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in the marketplace, what the market will bear and your standard negotiations, give and take with the pharmacies, if we have to negotiate. But our close relationships with our small local pharmacies helps us to have a feel for what's fair and reasonable in the marketplace.

Q Um-hum. Now, when we were talking about the physician-administered reimbursement for drugs, you said that you didn't know what the acquisition cost was of the providers. Correct me if I'm wrong, but I think that's what you said.

A I think that's correct.

Q Okay. Do you similarly not know the acquisition costs of the pharmacies?

A No, I don't know.

Q Okay. Would it make any difference to you to know the acquisition cost?

A I'm not sure I understand the question.

Q Well, have you ever asked any pharmacies what their acquisition costs are?

A Not that I'm aware of.

Q Okay. Is it at all relevant in your

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determination of reimbursement what their acquisition costs are?

A What's relevant in determining our -- what we're going to pay for those pharmaceuticals is back to fair and reasonable. You know, we don't know what the acquisition cost is. How it would factor in what we do, I don't know, because we don't know what it is.

You know, again, our goal is to be fair and reasonable. And if that information showed that what we were providing wasn't fair and reasonable, it would have some effect. If it showed that what we were doing was fair and reasonable, it would have no effect. It would be pure speculation on my part, which I'm not really one to do, because I don't know.

Q Have you ever heard of the term "WAC", wholesale acquisition cost?

A Just through course of preparing for this, reading this document.

Q I mean, is that a -- a term or a factor in any of the decision-making of Blue Cross/Blue

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Shield of Mississippi?

A No.

Q Now, in connection with brand drug reimbursement, you said that it's AWP minus a certain percentage. Why has AWP been chosen as the benchmark?

A It's just the point of reference that we chose. Honestly, I'm not sure what else would -- is available to be utilized, but it's the point of reference that Blue Cross/Blue Shield of Mississippi said was what we were going to use. I mean...

Q Is it strictly a matter of administrative convenience?

A I would think that that factors into why we use it. You know, that's -- it's served its purpose for us over the years, and it's readily available information. And it's over the years been really the best point of reference available. So that would all factor in.

Q Now, do you have an understanding that AWP is higher than the acquisition cost of the pharmacies?

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A I don't -- I don't know how AWP stands in relation to actual acquisition cost.

Q Do you have any expectation of a -- of a relationship between AWP and acquisition cost?

A Well, I mean, I -- you know, I would -- I would have to assume that it costs less to acquire the drug than AWP because they accept reimbursement at less than AWP. I mean, I'm a reasonably intelligent person and can draw that conclusion. But what the actual acquisition cost is, I don't know.

Q Is there any -- is there any -- is the pharmacy group that you discussed earlier that does the PBM function -- are they responsible for negotiating the contracts with pharmacies?

A Insomuch as negotiation -- like I said, it's -- it's become a very routine process for us, and it's typically handled through an administrative area that just handles the paperwork. There's very little negotiation that goes on any longer. If we made a decision to recontract, there would probably be several areas involved in that, but the pharmacy

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area would be -- have primary responsibility for it.
Q Do you know, does that department, that administrative area have a name?
A Provider administration.
Q Now, you said it's fairly routine. I mean, how -- do you have any understanding of how the -- what the mechanics are of the negotiation?
A Well, I think what I was trying to express is that there's very, very little negotiation that actually takes place. Provider administration is a clerical staff that basically processes paper. A pharmacist calls and asks for an application to participate. We send them all the standard information.
The typical process in probably 99 out of a hundred sign it and mail it back as standard course. If there were questions about contract language, of course, our legal staff would be involved. If there's questions about reimbursement, the pharmacy staff would review it. But I work very closely with that area, and I can't remember the

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last time we actually negotiated a pharmacy contract. It's fairly standard.
Q Is it -- is -- do most of the pharmacies in the state that you contract with obtain the same reimbursement for the same drugs?
A Again, I'd speculate. I don't know what each individual pharmacy has. But I would think it's fairly consistent.
Q Okay. Is it within a fairly small range? Is that fair to say?
A I would think so, yes.
Q Okay. Do -- do pharmacies -- strike that.
Does geography play any role in determining what reimbursement you'll pay to a given pharmacy?
A I don't believe so.
Q Does the size of the pharmacy play any role? I guess what I'm getting at, does a small pharmacy garner large -- maybe a larger reimbursement or a smaller reimbursement as compared to a big chain?

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A I don't have the reimbursement here to compare. You know, again, it would be speculation on my part. I would think that size of the pharmacy and community need might factor in. You know, if you're a single pharmacy in a single county in rural Mississippi, there's more community need, and that may factor into reimbursement more than actual size of the pharmacy.
But, actually, location and need, some of those things would factor in. But like I said, it's pretty standard, and I don't know that there would be many exceptions for that.
Q Are those -- are -- are issues such as community need something that's taken into account generally in your reimbursement rate making?
A It's involved in all the decision-making that we do. We have subscribers that look to us to provide comprehensive coverage, and so it factors in. Now, how it affects negotiations really depends on the situation in the area. And I wouldn't consider it the primary factor in any discussion that we have. We try to be -- I'll have to go back

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to fair and consistent -- I mean fair and reasonable. And that -- part of that has to be consistency.
Q Okay. Now, you testified about the use of the MAC list before. Is that same MAC list or whatever you want to call it, fee schedule -- is that applied to every pharmacy across the board, or does it -- or do you have more than one?
A We have -- we have one, and it -- I believe it applies to all. But, you know, there -- I'm not familiar with every individual pharmacy contract, but I -- it's -- to the best of my knowledge, it applies to all.
Q Okay. Now, I think the answer to this is probably no, based on your prior testimony, but does Blue Cross/Blue Shield of Mississippi use a usual and customary charge in any of its reimbursement formula or methodology?
A No.
Q Okay. Have you ever --
A Let me -- let me clarify that statement, though.

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Q Sure.
A The state and school employee health plan which we administer claims for does apply a usual customary reasonable schedule to out-of-state providers. That's a decision that was made by the State of Mississippi, not Blue Cross, as part of our contract with them.
Q Okay. If -- does Blue Cross/Blue Shield of Mississippi reimburse pharmacies outside of its network in any circumstances?
A That would all depend on the subscriber contract and speculation on my part, and I don't feel comfortable doing that. I mean, it all depends on those subscriber contracts, and I don't know if any of them have benefits for non-participating providers or not.
Q Okay. When you're setting the fee schedule or the rate, the methodology for reimbursement of pharmaceuticals for drug stores, do you expect -- do you expect that the pharmacy is going to make some margin on each prescription that they fill?

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A Well, like I said in earlier testimony, we -- we are not trying to pay less than cost to any provider. I mean, we understand that most providers -- you know, they're are obviously not-for-profit entities in the world, but most providers like pharmacies are in business to make a living. And we're not trying to deny anybody that living. So, yes, it would be our expectation that they do make -- make money on what they provide.
Q Um-hum.
A But we -- again, we're -- I'll have to go back to fair and reasonable. That's our only expectation is that what we're paying is fair to us and to them and to our subscribers.
Q Now, in terms of the -- the dispensing fee portion of the reimbursement, is -- I'd like to better understand how you -- how you view that -- that portion of the reimbursement. And I -- and what I'm getting at is, do you see that as a -- just another part of a reimbursement that leads to a given dollar amount, or do you see these as distinct in that the AWP minus reimbursements of the drug and

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the fee reimburses the actual cost of dispensing the prescription?
MS. FEGAN: Please repeat the question back.
MR. ROBBEN: Can you read it back? I think I'll ask it again.
MS. FEGAN: Okay.
MR. ROBBEN: Or I'll change it.
MR. ROBBEN: (Continuing.)
Q When you pay a dispensing fee as part of your reimbursement, do you understand that that fee is covering the actual cost to the pharmacy of dispensing that prescription?
A I just consider it a -- part of the component for reimbursement for pharmaceutical. I mean, it -- my assumption would be that that's -- covers the cost of providing that -- or filling that prescription. But, you know, in the -- in the global sense, I mean, I'm looking at overall reimbursement pharmaceuticals. It's just one component of it.
So I don't -- I mean, I don't give a

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whole lot of individual consideration to does this actually cover the cost. I make an assumption that it -- that that along with what we pay for the drug combined provides -- pays for the drug and covers the cost plus, you know, some margin to the pharmacy for providing that service to our subscriber. That's the way we would consider it.
Q Now, in setting reimbursement rates for the pharmacy-dispensed portion of the market, have you ever looked to any studies or publications to see what's being said in the literature about pharmacy costs, what's reasonable reimbursement, issues along those lines?
A I mean, as a company, we -- we obviously read publications and literature that's out there. Just as part of -- or the intelligence gathering that's necessary in being in the business that we're in. I can't quote specific sources because I don't -- I can't call them to mind right at this point. But it would obviously keep our -- we're obviously -- because of the business we're in, we're reading literature and -- insofar as gathering

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intelligence about our business.
Q But no one study or one publication stands out to you sitting here?
A Not sitting here, no.
Q Okay. Now, I think I asked you this in the -- on the physician-administered reimbursement side, but is there any overall plan or strategy to try and drive your reimbursement cost down on the pharmacy side?
A Well, there -- there's no strategy to reduce what we pay for any particular prescription. Now, of course, we're -- like every insurance company, we're concerned with trend -- our healthcare trend, and so we've got programs like a disease specific pharmacy program that looks at extremely high cost drugs and implements a prior authorization program to make sure that the people that are getting the drugs are the people that need those particular drugs and that all the criteria is met. Those sorts of programs are in place.
We have a disease management program built around diabetes that is not just focused on

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pharmacy costs, but overall costs of diabetics. Our big initiative at Blue Cross for the foreseeable future is to make Mississippi healthier, and part of that is going to be pharmaceuticals, not necessarily driving the costs down, but making sure that people are getting the meds they need at the right times to help reduce other things.
So we're looking at pharmacy costs, but not -- not necessarily how to drive it down, but how to spend pharmacy dollars more appropriately. That's really our focus.
Q Okay. Now, does Blue Cross/Blue Shield of Mississippi have any contracts of what are commonly known as specialty pharmacies?
A Yes.
Q You do? What's the -- what specialty pharmacy do you contract with?
MR. DONNELL: Are you asking the type of specialty or what specific specialty pharmacy?
MR. ROBBEN: Do you -- do you have a concern about the specific name?

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MR. DONNELL: Yes. It's a private contract between private entities that should not be disclosed.
MR. ROBBEN: Okay.
MR. ROBBEN: (Continuing.)
Q What -- what type of specialty pharmacy services do they provide?
A One of them provides some sort of hemophilia drug. Another provides some sort of drug for pediatric respiratory issues. I don't know the specifics of what drugs they actually provide, but that's general categories. A few provide biotech drugs, hepatitis C drugs, those sorts of drugs.
Q Okay. How are those -- are these very -- are these different entities, or are is it one entity that provides all of these service?
A I believe there's a few different entities. Some provide more than one drug. Some provide one single drug.
Q Okay. Now, do you know the process by which these specialty pharmacies are selected?
A There was some sort of request for

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information or request for proposal-type process, but I honestly was not involved in that process.
Q Okay.
A And then others, I guess, if they're single source -- I mean, it's a direct contractual negotiation.
Q Do you know how -- do you know the methodology by which drugs dispensed through these speciality pharmacies -- do you know that methodology?
A Most of the drugs that are in that program are dispensed in the physician's office.
Q Uh-huh.
A But the physician would contact the specialty pharmacy and order the drugs. The pharmacy would bill us directly, and we would pay them based on the NDC code using an AWP minus some percentage formula. I do not believe there's a dispensing fee involved in those arrangements.
Q Okay. Is that -- is the minus in AWP minus, is that percentage negotiated?
A It's -- it would be negotiated, yes.

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Q Do you know the factors that go into that negotiation?
A I'm not sure what you mean by factors.
Q Well, is the goal of the negotiation for Blue Cross/Blue Shield of Mississippi just to pay the least amount possible?
A I don't know that I could characterize the goal of negotiation to be that. I mean, it's obviously one of the factors in -- in negotiating with a -- with a specialty pharmacy is to receive better reimbursement than you could get by opening it up to everybody. My assumption would be, you know, part of that is just volume buying type -- you know, standard business practice arrangements.
But I think really the more important goal is some of the other things that we gain by using specialty pharmacies like provider education, prior approval processes where they have clinical staff that evaluates the patient to make sure that they're the right match for that drug, and then patient education component.
I mean, take hepatitis C for an example.

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I mean, it's a very, very terrible disease that people need a lot of education to understand the importance of getting your drugs at the right time, that you're educating the providers on, you know, what intervals the drugs have to be administered.
So the goal of the negotiation would be all of those things together. And in the end, you know, there's -- there's an effort to try and get the best price possible obviously. But that's not the sole intent of the negotiation. We look for other things as well.
Q Is it fair to say you're -- when you're contracting with a specialty pharmacy, you're not just contracting to obtain the drug at the best price. You're contracting for sort of a bundle of various services and price might be a factor?
A I think that's a fair assessment.
Q Okay. Now, do you have any -- how long have these specialty pharmacies been contracting with Blue Cross/Blue Shield?
A I have to guess. I mean, it's been less than ten years, but probably around six.

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Q Okay.
A And as more drugs come out, pharmacies are added. You know, as you get a biotech drug or something that comes out that has a very specific niche of patient, we want to make sure -- we don't -- we want the patients who need the drug to get the drug, but we don't want it wasted on people that don't need it.
So we will -- we will put those sorts of programs in as those drugs emerge. And it's probably been within the last ten years that we've really started to see those sorts of drugs emerge -- or at least on our landscape.
Q Well, what -- you might have answered this, but how are these particular drugs -- and I know you don't understand -- you don't have a full knowledge of all of them. But how were these chosen as drugs that you need a specialty pharmacy to -- to dispense them?
A I'm not -- I'm not involved in those decisions. Our clinical staff looks at that. Pharmacy staff, our medical management staff, our

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medical director, our corporate medical advisor, they're all involved in those.
And they -- you know, I'm a reimbursement person, so I'm not necessarily looking at emerging pharmaceutical technology; but those -- those people are. They're looking at -- at disease states. Hepatitis C is a good example because of the transplant rate. People that have hepatitis C -- I mean, it's clear that you need a program that revolves around patient and physician education. And in the end, because it's expensive, you try and get the best price possible.
But those -- those folks are looking at those things saying, you know, where -- you know, where are the real opportunities to -- they're case management opportunities also. These patients don't just need drugs. They have other health issues. So our case managers would get involved to help them maximize their health insurance benefits. So it's an integrated effort from our clinical team, which I include the pharmacy staff in that team.
Q Um-hum. How is the -- how has the

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reimbursement paid by Blue Cross/Blue Shield Mississippi changed from the period before you had the specialty pharmacies to the period after? Were you paying more? Were you paying less?

A I don't know the answer to that.

Q Okay.

A And to qualify why I don't know, I mean, that's not really the end goal. That's just a component. The success of those programs is not driven by savings, but -- our pharmaceutical savings, but education and all of those other things that we're trying to do. So while you may not see a reduction in pharmaceutical costs, you may see savings in other areas because you avoided hospital admissions, transplants, and some other things. But to be honest, I don't know the answer.

Q Okay. Now, do you have any contracts, or do you have a relationship with a mail-order pharmacy?

A I know that we have in the past. I don't know if it's currently operating.

Q Do you know -- do you know why that

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relationship ended?

A I don't know that it did.

Q Oh, okay.

A I just -- I think it -- that really depends on the group and the benefits and those sorts of things. But I don't think we have a strong mail order presence if we have one at all.

Q Okay. Do you have any familiarity with drug wholesalers?

A I don't.

Q You don't? Okay. So you -- strike that.

Well, let me just ask for the record, do you have any awareness of how they buy their products and the prices for which they obtain them?

A No.

Q Now, in this case, there's various allegations about drug manufacturers trying to artificially inflate the AWP of various drugs.

Do you have any knowledge of any activity by drug manufacturers to inflate the AWP of their drugs?

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A No.

Q Now, do you -- in a similar vein, do you have any knowledge of any pharmacy or doctor or PBM conspiring with a drug manufacturer to inflate or change the drug's AWP?

MS. FEGAN: Objection to form. It calls for legal conclusion.

MR. ROBBEN: (Continuing.)

Q You can answer.

A No.

Q Now, has Blue Cross/Blue Shield of Mississippi been involved in any litigation regarding AWP, to your knowledge?

A Not that I'm aware of.

Q Okay. Are you aware of a study called -- generally known as the Dyckman study?

A No.

MR. ROBBEN: Now, I don't -- I don't have anything else; although, some of the people on the phone may.

MR. MANGI: Yeah. This is Adeel Mangi at Patterson Belknap for J & J. I

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do have some questions. Shall I do them first, or would counsel for the plaintiffs prefer to go?

MS. FEGAN: You can go ahead because it's probably still part of direct, right?

MR. DONNELL: Let's take a five-minute break. This is counsel for Blue Cross. Just five minutes.

(Off the record.)

EXAMINATION

EXAMINATION BY MR. MANGI:

Q Mr. Brown, my name is Adeel Mangi. I'm an attorney with Patterson, Belknap, Webb & Tyler in New York. We represent the J & J defendants in this case.

A couple of preliminary points. First, I apologize I can't be there in person. If you have any trouble hearing me, please let me know, okay?

A Okay.

Q Secondly, I'm going to do my best to avoid repeating anything Mr. Robben has already

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asked you about. But there may be areas we touch upon, so I'll ask for your indulgence as we go through those, okay?

A Okay.

Q First of all --now, as I understand it, Blue Cross/Blue Shield of Mississippi reimburses for drugs both when they're administered in physicians' offices and when they're dispensed through pharmacies, correct?

A I think that's very general, but, yes, correct.

Q Can you estimate the percentage of total reimbursement dollars that Blue Cross/Blue Shield of Mississippi pays that relate to drugs reimbursed -- for drugs administered in physicians' offices versus through pharmacies?

A I don't have that information available.

Q Do you know whether it's a small percentage or a large percentage?

A I'm not sure. I mean, I don't know that I could characterize small or large. I don't -- I don't have the information in front of me.

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Q And it's fair to say the amount in dollar terms that Blue Cross/Blue Shield of Mississippi reimburses to physicians' offices is a significant amount regardless of whether or not it's a large percentage of overall reimbursement dollars?

MS. FEGAN: Objection to form.

MR. DONNELL: Let me step in there. That's -- that's outside of the scope of the agreement that we had as well.

MR. MANGI : Actually directly relevant because it goes to the issue of active management of reimbursement and setting of methodologies. It's a quick question, and I won't be staying long on the topic.

A I'm not sure I understand the question. Can you repeat it, please?

MR. MANGI: (Continuing.)

Q Blue Cross/Blue Shield of Mississippi does have a fee schedule by reference to which it reimburses physicians for drugs administered in

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office, correct?

A Correct.

Q That fee schedule is changed or updated either annually or sometimes more frequently, correct?

A It is reviewed annually and updated periodically.

Q So it's fair to say, then, that Blue Cross/Blue Shield of Mississippi does pay some careful attention to the amounts that it's reimbursing physicians in relation to drugs administered in office, correct?

A Well, as I said before, our goal is to provide fair and reasonable reimbursement, so we take great care in all of our reimbursements.

Q By fair and reasonable, I wrote down your testimony earlier. I believe you said that you understand providers are there to make a living, and you don't have any qualms with that, correct?

MS. FEGAN: Objection. If you're just asking him to verify if that was his exact quote, I have a problem with

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that. It should be read back by the court reporter. So I'm going to object to mischaracterization.

MR. MANGI: Fine.

MR. MANGI: (Continuing.)

Q The question is, do you recall that testimony?

A I don't recall exactly what I said, but I recall something similar to that.

Q Okay. Is it fair to say that by fair and reasonable reimbursement, Blue Cross/Blue Shield of Mississippi intends to reimburse providers at an amount that will cover their costs and enable them to make some profit?

A Well, as I said before, it's not our goal to pay below cost and that we understand that -- that providers have need to make a living. And so all of that is in -- is factored into our reimbursement schedules.

Q So you agree with my statement?

A Well, repeat your statement.

MR. MANGI: Would the court

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reporter mind reading back my previous question?
(Previous question read back by the court reporter.)
MS. FEGAN: Objection to form. It mischaracterizes the witness's testimony.
MR. MANGI: You can answer.
A I mean, I would say that that is -- that is a good summary of what I said, yes.
MR. MANGI: (Continuing.)
Q Now, you also said AWP is a point of reference in establishing reimbursement. Do I understand correctly that -- well, withdraw that question.
Let me ask you this. You don't know what any particular providers are paying to acquire drugs, correct?
A I mean, not unless they provide the information to us in the form of a request for a change in reimbursement on a particular code. But globally what's paid for a particular drug, no, we

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don't know that.
Q You would only get that information in isolated instances where a provider is complaining reimbursement is too low and doesn't cover his costs, correct?
A That's correct.
Q And, indeed, you are aware that acquisition costs for drugs will vary from physician to physician, correct?
A Well, I mean, I would assume that, but I don't have information back to what they've acquired the drugs for. I don't have actual information as to what each individual physician paid to acquire a particular drug, but it would be my assumption that that takes place.
Q Well, certainly, you're aware that no one pays AWP to acquire drugs in the market; is that correct?
A Well, I don't -- I don't -- I'm not sure that I can say that. Because I -- again, I don't know what they acquire it for. And I think your question was that I -- that I could safely say that

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nobody does. I don't know that to be true because I don't know what everybody acquires the drug for.
Q That goes, then, to the reimbursement methodology. Now, you testified earlier that Blue Cross/Blue Shield of Mississippi reimburses physicians in relations -- in relation to drugs administered in office using J codes, correct?
A Correct. J codes and other HCPC codes.
Q Oh, a HCPC codes, which may be a -- which is usually a J code, but also could be a Q code, for example, right?
A I believe that it could be a Q code, yes.
Q Okay. Now, a J code is not specific to a particular NDC, correct?
A Correct.
Q One J code, for example, can include different branded drugs within it, right?
A I think we talked about that earlier, yes.
Q J code can also include a brand of drug and its generic competitors, correct?

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A Correct.
Q Or a J code could include just different generic competitors, right?
A Well, before I go too far -- farther with this, let me say I'm not an expert on NDCs and how they're tied to specific J codes, but it's my understanding that that's correct.
Q Now, it's fair to say, isn't it, that when you receive a claim from a physician in relation to a drug they've administered in office, on that claim, you only receive a J code and not an NDC, correct?
A We either -- we receive a HCPC code, correct.
Q Right. And your reimbursement is also by reference to that HCPC code, correct?
A Correct.
Q So it's impossible to relate your reimbursement to the particular AWP of any particular NDC. Is that a fair statement?
A I'm not -- I'm not sure I understood your question.

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Q Well, let me rephrase it. When a physician administers a drug, that drug is a particular drug that has a particular NDC associated with it, correct?
A I think in general, that's correct.
Q Okay. And if it's a branded drug, it will have an AWP associated with that NDC. As a general matter, you will agree with that, right?
A It should, yes.
Q The amount that Blue Cross/Blue Shield of Mississippi reimburses that physician in relation to that drug when it is issued to a patient is not tied to that NDC, correct?
A It's -- no. It's -- it's -- it would not be tied to a particular NDC. We wouldn't -- we wouldn't have any idea what NDC -- the NDC number for the drug that was actually administered. All we would know is the HCPC code that they submitted for that drug.
Q Oh, so you don't even know what particular NDC drug was administered to the patient, right?

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A That's correct. Unless for some -- for some reason they submitted medical records with the claim for another processing purpose, we would not know that.
Q This would be an isolated exception?
A That would be a -- you know, the rare exception.
Q Well, certainly, Blue Cross/Blue Shield of Mississippi, when reimbursing physicians for drugs administered in office, does not relate its reimbursement to the AWPs of any particular drug's NDCs. Is that a fair statement.
MS. FEGAN: Objection to form.
A Can you repeat that, please?
MR. MANGI: Could the reporter please read back my question?
(Whereupon, the question was read back by the court reporter.)
A Well, I mean, again, AWP is used as a point of reference in calculating the AW -- excuse me -- the allowance for a particular HCPC code. But, again, we don't know what particular drug was

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administered. We just know the corresponding HCPC code, and we would reimburse our set rate for that HCPC code. It would not be tied to the NDC of the actual drug that they supplied.
MR. MANGI: (Continuing.)
Q You mentioned the role of AWP in generating the amounts paid. You're referring there to generation of the fee schedule, correct?
A I'm sorry. I didn't understand what you asked.
Q All right. Well, let me rephrase the question. Reimbursement of two physicians for drugs administered in office is made by Blue Cross/Blue Shield of Mississippi by reference to a fee schedule, right?
A Right.
Q Does Blue Cross/Blue Shield of Mississippi generate that fee schedule?
A Yes.
Q Are there more than one fee schedule at any given time, or is there just one?
A Well, based on the date of service of

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the claim, there would just be one. But we obviously have iterations of that schedule based on runout of claims. And to further explain that, you know, the new fee schedule would be updated effective, you know, today, but if we got claims for yesterday, they would pay on the previous iteration. So there are three iterations that are kept so that we can -- that we can process runout of claims. But for a given date of service, there's only one fee schedule.
Q How is that fee schedule generated?
A It's developed internally.
Q Who's responsible for that process?
A Me.
Q How do you go about generating the fee schedules? What information do you consider, and what calculations do you perform?
A I'm not sure what you're asking me.
Q Well, I'm trying to figure out how you go about physically putting together a fee schedule. Can you describe that process for me, please?
A We would take the existing schedule. We

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would pull actual claims utilization by procedure code. We would look at our -- our relevant market intelligence of our understanding of our current schedule. We would look at various points of reference.

We talked about Medicare. We have an understanding of where they are, though we don't use it to develop the schedule. We would look at the average wholesale price, prices for the drugs corresponding to the individual HCPC codes. And from there, we would use our own knowledge and understanding of the marketplace to establish an allowance.

I mean, the calculation in and of itself can be different per year based on what we understand or our understanding of the marketplace. But those -- all those factors are considered. Then we would prepare various models of changes, run utilization through it to see the impact of those changes to both us and to the provider community. I would develop a recommendation and then submit it to executive management for their approval.

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Q Is it fair to say, then, that AWP is just one of many factors that you consider when developing a fee schedule?

MS. FEGAN: Objection to form.

A I would say it's -- it's one factor that we look at. It's not the sole factor for our decision.

MR. MANGI: (Continuing.)

Q It's one of the points of reference that you use, correct?

A That is correct.

Q You also use other points of reference, such as CNS, right?

A Correct.

Q And there are other factors which are not points of reference, but are building blocks of information that you use to generate the fee schedule?

A Well, the difference between a point -- a point of reference and a building block, I'm not sure what you mean by that. But I think they're all integral components that are used to develop that

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schedule or to evaluate it.

I mean, as I've said before many times, there aren't changes that are made because we're comfortable with what our reimbursement is, and our provider community is -- finds it acceptable; and so we don't make changes. But all of those components that you mentioned are used in evaluating the existing schedule and preparing proposed revisions for executive sign off.

Q AWP is just one of those factors?

A That's correct.

Q Now, you mentioned earlier that the drug component of the fee schedule -- in other words, the amount that Blue Cross/Blue Shield of Mississippi reimbursed physicians for the drugs they administer in office is not subject to negotiation, correct?

A Well, what I said is we have one statewide fee schedule and that if -- if there were individual concerns regarding particular reimbursement on a J code, that if -- if we found it necessary to make an adjustment, then all physicians and providers that use that fee schedule would

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receive that adjustment.

Q So there are no individual negotiations that only impact the amount reimbursed to an individual physician, correct?

A Correct.

Q Does that apply also to the service component of the fee schedule? In other words, is there individual negotiation of reimbursement for services?

A I don't know what you mean by services.

Q Well, Blue Cross/Blue Shield of Mississippi reimburses physicians not just for drugs, but also for the services -- the medical services that they provide, correct?

A That's correct.

Q For example, if an injectable drug is being administered to a patient, Blue Cross/Blue Shield of Mississippi will reimburse the physician an amount in relation to the drug and an amount in relation to administering the drug, correct?

A Provided that CPT coding rules allow for that.

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Q All right. Provided that there is a code for the service that's at issue, right?
A And provided that the service being provided is a covered service under the subscriber's contract, the answer to that would be yes.
Q All right. Now, those services -- in other words, components of the fee schedule other than the purely drug components, are those subject to negotiation?
A We have one statewide fee schedule that's applicable to all physicians. So similarly to J code reimbursement or HCPC reimbursement, if we found it necessary to make an adjustment to an individual code, the adjustment would be made for all physicians.
Q And the adjustments are made in cases where either providers give you information saying the amounts they're reimbursed are too low or where they say the amounts they're reimbursed are too high; is that correct?
A That's correct. While the latter doesn't happen very often, it does happen.

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Q How often has that happened, where a -- where providers tell you that the amounts you're reimbursing are too high?
A Well, I don't -- I couldn't tell you how often it happens. It's very rare, but it has happened.
Q Has it happened more than five times, to your knowledge?
A In the span of how long?
Q Since you've been work --
A Since 1949 or since I've been working there or --
Q If you know since 1949, I'd be happy to know, but if you don't, since the time you've been working there?
A I would just say a handful.
Q Okay. Give me just a moment. Flipping a few pages here.
Now, the amounts that physicians pay to acquire drugs only come to your attention when a physician makes a complaint, correct?
A Well, I'm not sure I'd characterize it

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as a complaint, but when they communicate that information to us.
Q Okay. Now, if Blue Cross/Blue Shield of Mississippi were to discover that a particular physician were getting a rebate or a discount from a manufacturer that substantially lowered their acquisition costs, that wouldn't result in a change of reimbursement to that individual physician, correct?
MS. FEGAN: I'm sorry. Could the question be read back, please?
(Whereupon, the question was read back by the court reporter.)
MS. FEGAN: Objection to form.
A As I stated before, we have one statewide fee schedule, and I've not been faced with that situation to know -- I mean, to have experience on how it would be handled. But, again, we would have to evaluate the -- the fee schedule from a global perspective from all of our physicians, and -- because we don't pay individual schedules to individual physicians.

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We would have to do some evaluation of the actual allowance and does the allowance continue to be fair and reasonable to all physicians and to Blue Cross and our subscribers. Depending on all those results, you know, a decision would be made. But I don't -- I can't speculate on what the decision would be without all of that information.
MR. MANGI: (Continuing.)
Q Well, if some physicians were getting a rebate from a manufacturer on a particular drug and others were not, then Blue Cross/Blue Shield of Mississippi would not change the reimbursement because you want to be fair and reasonable to all the physicians including those who are getting the rebate. Is that a fair statement?
MS. FEGAN: Objection to form.
A Well, again, I'm not sure that I can answer your question because I'm not faced with that situation and able to evaluate that. I mean, our current practice is one statewide fee schedule. Would we change that practice if we determine something like that was taking place? I can't

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answer that because I'm not faced with that decision.

I don't know how -- I don't know that the practice happens or is prevalent or how that affects what is fair and reasonable. All of those questions would have to be answered before I think I could answer the question that you've asked.

MR. MANGI: (Continuing.)

Q Do you know whether or not physicians contract in any cases with manufacturers to get rebates and discounts on drugs?

A I don't have any idea.

Q Now, I believe you agreed earlier that acquisition costs for drugs could vary from physician to physician, correct?

A I think what I said is that I didn't know whether it did or didn't. My assumption would be that it does. But I don't know whether it does or doesn't.

Q Well, certainly, we can agree that the AWP for any given drug bears no fixed relationship to acquisition costs for that drug, correct?

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A As I've said before, I don't know where average wholesale price comes from. So the relation of average wholesale price to acquisition cost is not something that I'm familiar with. So I don't know that I can agree or disagree with your statement.

Q Then it's certainly fair to say you have no particular expectation that there will be a fixed relationship between AWP and acquisition cost?

MS. FEGAN: Objection to form.

A Average wholesale price is a point of reference that we use. It's relation to acquisition cost, I'm not familiar with. So, I mean, I don't have an expectation one way or the other on that.

MR. MANGI: (Continuing.)

Q Certainly, you don't have an expectation that acquisition costs will be 20 percent less than AWP, 40 percent, 80 percent. You just have no expectation at all about that; is that a fair statement?

MS. FEGAN: Objection to form.

A I mean, I -- all I can -- all I can

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answer to answer honestly is I have no understanding of the relation between the two. And to speculate on, you know, what is and what isn't the relationship, I'm not comfortable doing.

MR. MANGI: (Continuing.)

Q So it's fair to say, then, certainly you have no expectation of what the relationship is either, correct?

A I think it's fair to say I don't know what the relationship between the two is. And we strictly use AWP as a point of reference, and that's really all I feel comfortable responding to.

Q On a separate note, you mentioned that CMS fee schedules are used as a point of reference in generating your fee schedules, correct?

A I said it is another source that we look at just so that we have an understanding of what's going on in the marketplace. It's not a point of reference in the same sense that average wholesale price is. Our -- our reimbursement is not based on what Medicare's reimbursement is.

Q Do you -- does Blue Cross/Blue Shield of

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Mississippi act as a Medicare carrier?

A Blue Cross/Blue Shield of Mississippi has a subsidiary company called Tri-span that is a part A intermediary.

Q Are you involved at all with the activities of Tri-span?

A I am not.

Q Does Blue Cross/Blue Shield of Mississippi offer any Medicap or Medigap or other supplement insurance?

A We offer Medicare supplement policies.

Q And is that -- are those policies intended to cover the copayment due from Medicare beneficiaries?

A I think I mentioned before that I'm not an expert on benefit plans, and I -- I'm even less an expert on Medicare supplements. It's my understanding that those are standardized plans, that the government standardized those plans, and we apply whatever those standard benefits are. But what those are, I have no idea.

Q So you don't know what percentage of the

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copay those policies cover; is that correct?
A I have no idea.
Q Switching to another area again, does Blue Cross/Blue Shield of -- I'll withdraw that.
We can agree that there are some drugs that can be administered either in a physician's office or in a hospital setting, correct?
A I can't answer that question. I'm not a clinician. I don't -- I don't -- I don't know what particular drugs -- I don't even know what -- I don't know what they do. I'm strictly reimbursement.
Q Well, do you -- do you reimburse both hospitals and physicians in relation to any of the same drugs?
A Well, I'm not sure I'm clear on your question. I mean, there -- I'm sure there are drugs that are given in physician's offices that can also be given in a hospital. But are they given for the same reason, et cetera, I don't -- I don't know all of that. But I guess it is safe to say that if a drug is clinically appropriate to be given in a

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hospital or a physician's office, that we would reimburse both places.
Q In those instances where a drug can be administered in either setting, does Blue Cross/Blue Shield of Mississippi have a preference as to the site of care?
A The most appropriate setting. That would be our preference.
Q Assuming that there are no clinical factors requiring administration in one setting or the other, has Blue Cross/Blue Shield of Mississippi ever assessed the relative costs?
A At -- at the prescription drug level? At the -- at the injectable drug level?
Q In relation to the drug component, yes.
A No.
Q How about in relation to the drug plus service component?
A Not -- not -- not focused in on prescription drugs or -- or injectable pharmaceuticals. We've not looked at it at that level that I'm aware of.

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Q Well, let me ask the question a bit more broadly to ensure that we understand each year. Does Blue Cross/Blue Shield of Mississippi or has it ever assessed whether it's more cost effective overall to the health plan if a drug is administered in a physician's office versus in a hospital?
A Well, I can't answer that question because I think there are other factors that are involved. Again, our preference is the most appropriate setting, whether that's the hospital or the physician's office.
Q I'll ask you to assume that there is no clinical reason for one setting versus the other.
A I -- we've not done that study, so I can't answer the question. I mean, again, our preference is the most appropriate setting, and then, you know, I would think at some -- at some level, you know -- I mean, our clinicians are the ones that determine -- you know, would be involved in what's the most appropriate setting. And I think that's really the most important piece for us.
Typically, members have physician office

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copays versus deductible and coinsurance in a hospital. So I would think from that standpoint, the member would be more interested in doing it in a physician's office. But, again, back to -- from our standpoint, the first criteria would be the most clinically appropriate setting. And I'm not sure that -- I mean, I -- I don't know enough about prescription -- or pharmaceuticals to know if they're -- if a hospital and a physician's office can be -- both be the most appropriate setting.
Q Now, turning to another area again, earlier today you -- you used a phrase. You stated that Blue Cross/Blue Shield of Mississippi deals with the big picture fee schedule. Do you recall using that phrase?
A I think when I was saying that is that I deal in the big picture fee schedule.
Q Okay.
A But I'm not sure -- I don't remember in relation to what discussion we were having.
Q Can you -- can you help me understand what you mean by that phrase in dealing with the big

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picture fee schedule?
A I would need to know the context of the testimony to -- to know what I was talking about.
Q Let me back up and ask you the question more broadly, then. When -- when Blue Cross/Blue Shield of Mississippi is assessing the amounts it pays in reimbursement or carrying out the reviews that we have discussed, does it look at the drug component of its fee schedule in isolation, or does it consider the fee schedule as a whole?
A Well, we take -- we -- there are several components to an overall fee schedule, not just the drug component. And we'll look at each component but then look at the overall component. So we don't -- I mean, none of it's done in a vacuum. I mean, it's all an integral part.
Back to -- to being fair and reasonable, you can't be -- you can't be unfair in a certain area and then try to get back to being fair overall. I mean, we have -- we do look at components, but in the end, we're evaluating the overall reasonableness of our professional provider reimbursement.

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Q It's fair to say that -- then that -- to use your phrase, we're looking at the bottom line, what's paid for reimbursement as a whole. Is that a fair statement?
A Well, I think it's fair to say that that's definitely part of the overall analysis, but we do look at individual components; and we do look at individual specialties. Again, our overriding goal is to be fair and reasonable. And to do that, you have to understand the effect of changes that you make down to the individual speciality level.
So we do that, but we are focused on the big picture of the fee schedule reimbursement. We have to -- that's back to being fair and reasonable to -- to our participants and to Blue Cross. So I think -- I think they're both individual components.
And, again, I don't remember the context of the discussion where I said the big picture to know if that's what we were talking about.
Q Now, Blue Cross/Blue Shield of Mississippi does have competitors in the Mississippi market, correct?

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A As I said before, I'm not familiar with who they are, but I know that there are some out there, yes.
Q Is strength of provider network one grounds of competition?
A I didn't -- I didn't understand your question. I'm sorry.
Q Blue Cross/Blue Shield of Mississippi has to sell its products to customers, right?
A Right.
Q When it seeks to market its products, one aspect of marketing is the strengths of going with Blue Cross/Blue Shield of Mississippi as against its competitors?
MR. DONNELL: Are you getting to a deposition topic that we've agreed upon?
MR. MANGI: Yeah, absolutely.
MR. DONNELL: Okay. Which one?
MR. MANGI: It is the factors that go into the settings of reimbursement methodologies. And if you'll allow me to ask two more questions, you'll see

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the relevance of it.
MR. DONNELL: Okay. He has asked -- he has been asked that question over and over and over, what methodologies and factors he's considered. Competition was not among them. So if you'd like to move on, I'd appreciate it.
MR. MANGI: With respect, that's exactly the question that I'm getting at, as to whether or not strength of provider network is a factor that's used in selling products as a -- as a grounds of competition. It's certainly encompassed by the deposition topics. I intend to spend no more than a minute on it, sir.
MR. DONNELL: Okay. Well, he's asked -- he's been asked that and answered that. But if you would move quickly through that, I'd appreciate it.
MR. MANGI: I will.

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A I -- you know, I don't know that I can answer that question. I don't market Blue Cross products. I don't sell health insurance. So the marketing strategy, I'm really pretty well removed from.

MR. MANGI: (Continuing.)

Q Okay. Well, let me ask you this, then. When you conduct reviews of the fee schedule, is one factor you consider the strength of your network relative to your competitors?

A I can tell you I'm completely unaware of their networks. I don't -- I'm not -- I am not concerned with their networks. I am concerned with my network. And as I've mentioned before, we have very strong relationships with our providers, and I am more concerned with those relationships than I am with what our competitors are doing in the marketplace.

I mean, it really -- at this point -- and not to say that in the future it won't -- it won't factor in. But at this point, I've never considered what our competitors are doing when developing our

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reimbursement rates.

Q Give me just a moment. Let me flip through a few pages here.

Now, I'd like to turn to the -- the pharmacy side from the physician's side where we've been so far. You mentioned that the standard reimbursement methodology, AWP minus a percentage plus a --

A I'm sorry. You cut out.

Q I'm sorry. Let me repeat the question. In relation to how Blue Cross/Blue Shield Mississippi reimburses pharmacies for drugs administered to members, for branded drugs the methodology at present is AWP minus a percentage plus a dispensing fee, correct?

A Correct.

Q What is that percentage at present?

A I don't know. It varies.

Q Okay. So is there one percentage that applies in most cases, or is there a broad variation?

A I don't know what it is.

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Q Okay. But you're aware of the fact that there is variation; is that a fair statement?

A There is variation, yes.

Q That variation is based on individual negotiations between Blue Cross/Blue Shield of Mississippi and pharmacies; is that a fair statement?

A Yes.

Q What sort of factors would give one pharmacy greater leverage as against another?

A I don't know what you mean by leverage.

Q Well, if there is a variation, that means that different pharmacies are getting different deals through a bargaining process, correct?

A Well, I mean, I -- I didn't sit down and negotiate those pharmacy contracts, so I can't assume that -- that all got better reimbursement because of what you call leverage. There could have been other factors to consider.

But as I said, I didn't sit down and negotiate those, so I would have to assume that --

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that some were able to get better pricing for various reasons like I talked earlier. Geography, you're the only pharmacy in town. There may be a need to make a different deal to include them.

But, I mean, there's a variety of factors that go into that negotiation, and because I wasn't present in those negotiations, I couldn't tell you what went into them.

Q Okay. So you're saying there that you don't know exactly what factors do impact those negotiations because you don't play a part in them; is that correct?

A That is correct.

MR. MANGI: For the record, based on the fact that this witness does not have knowledge regarding reimbursement methodologies employed in relation to reimbursing pharmacies or the factors that go into setting those methodologies, we will reserve our right to seek another witness who does have knowledge of these areas that are

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encompassed by the deposition subjects. If you'll give me a moment, I'll just look through a few more papers here.

BY MR. MANGI

Q Who is responsible for that negotiation process between Blue Cross/Blue Shield of Mississippi and pharmacies?

A Our director of pharmacy would be responsible for those, you know, in the event that that took place. As I said before, the process is very standard, and we don't -- I mean, I can't recall the last time we've had to negotiate with pharmacy.

Q Well, there is variation, isn't there?

A I think I've said that before, yes.

Q So if the basis for that variation is not negotiation, what is it?

A Well, as I said, we haven't done that in quite a while. Now, we've had contracts in place for many years. When those contracts were established, I assume that there was some

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negotiation that took place. I'm talking more -- more recent. We haven't recontracted our pharmacies in many years.

Q Now, in relation to generics, reimbursement is by reference to a MAC list; is that correct?

A Yes.

Q How is that MAC list generated?

A We purchased it. It's -- it's produced by CMS. The basis for it, I don't know how they create it, but that's who we use.

Q In relation to reimbursement to a pharmacy, you follow a -- one MAC list that's generated by CMS?

A Correct.

Q Also pay a dispensing fee in relation to those generic drugs?

A I believe so, yes.

Q How is that -- that generic dispensing fee calculated?

A It -- I believe it's the same dispensing fee as the brand. We have one dispensing fee, to

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the best of my knowledge.

Q Do you know whether reimbursements to pharmacies in relation to both branded and generic is only by reference to AWP minus or MAC or are those some benchmarks amongst others in that reimbursement formula?

A I didn't understand your question.

Q Yeah. Let me -- let me make it a bit clearer. Let's take generic drugs first. Is the reimbursement to pharmacies expressed simply as the MAC for that drug, or is it the MAC or another benchmark, whichever is lower, something like that?

A I believe it's just the MAC. I'm not aware of any other Benchmark.

Q And in relation to branded drugs, is just AWP minus a percentage, or is it that or the lower of some other benchmark or price?

A There's no other benchmark. So it's just AWP minus.

Q Are you familiar with the term --

A I couldn't hear you. You cut out.

Q I'm sorry. Are you familiar with the

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term "ASP"?

A Yes.

Q What is your understanding of what ASP stands for?

A Average sales price.

Q What is average sales price?

A My understanding is CMS is collecting information from various sellers and purchasers of the actual acquisition cost of a drug and that they -- they are publishing that in the federal register and using that for basing Medicare's reimbursement for physician office administered drugs.

Q Now, leaving aside the use of ASP in relation to Medicare reform and present, do you know whether ASP has had a standard meaning over time?

MR. DONNELL: Does this relate to anything that we've agreed to? And if so, point to it.

MR. MANGI: Again, this relates to consideration of alternative benchmarks in reimbursement.

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MR. DONNELL: Has he -- has he testified that he has considered ASP before now?
MR. MANGI: That's precisely the -- the area that we're getting at.
MR. DONNELL: Why don't you ask him that question?
MR. MANGI: Well, all right. Let's start with that.
MR. MANGI: (Continuing.)
Q Has Blue Cross/Blue Shield of Mississippi ever considered using ASP as a basis for reimbursement?
A Well, to the best of my knowledge, ASP was just recently released January 1 of this year by Medicare. As I've said before, we -- we monitor what Medicare is doing, but, you know, to this point, we've not considered converting or using ASP as our primary point of reference.
Will we consider it in the future? I can't answer that. We haven't made a decision to do that or not do that. We will continue to monitor

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what Medicare does so that we better understand the marketplace. At some point in the future, we may consider that. But right now, there's not an evaluation ongoing to determine to make a change.
I mean, we're familiar with what it is. We're monitoring it, as we did Medicare's old reimbursement system. But no decisions have been made to use ASP in calculation at this point.
Q Now, the dispensing fee component of reimbursement to pharmacies, does Blue Cross/Blue Shield of Mississippi have any knowledge as to whether that dispensing fee alone taken apart from reimbursement for the drug is sufficient to cover pharmacies' overhead costs?
MS. FEGAN: Objection to the form. Calls for speculation.
MR. DONNELL: Also asked and answered.
MR. MANGI: (Continuing.)
Q You can answer.
A Well, as I've said before, I don't know what it cost for the pharmacy to acquire the drug,

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and I don't know what it cost for them to dispense the drug. You know, again, my -- our goals in our provider reimbursement programs is fair and reasonable reimbursement.
So for providers to agree to accept our reimbursement, I have to assume the combination of our drug prices and our dispensing fee covers their costs and allows them to make the margins that they need to stay in business and to make a living. But knowledge of whether it does or doesn't, I don't have any way of knowing that.
Q In other words, your assumption is that the total bundle of reimbursement is sufficient to cover costs and provide some margin of profit, correct?
A That's my assumption based on the fact that pharmacies agree to our reimbursement programs.
Q And indeed, that's equally true on the physician's side, isn't it, the -- Blue Cross/Blue Shield of Mississippi's assumption is that the overall bundle of reimbursement should be sufficient to cover overhead costs and provide some margin of

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profit to the physician?
A As I said before, our goal is fair and reasonable reimbursement. We are not trying to make providers provide services at their cost or less. We understand that they're in business to make a living and that we have no problem with that.
So in a sense, when we look at the fee schedule, it's our opinion that it is fair and reasonable and offers enough to cover their costs and to make the margins that they need to make a living.
Q Well, you mentioned earlier that Blue Cross/Blue Shield of Mississippi does subscribe to Red Book; is that correct?
A Correct.
Q Do you use Red Book in your day-to-day work?
A My personal day-to-day work?
Q Uh-huh.
A No.
Q Have you ever seen Red Book? Have you had occasion to look through it?

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A Oh, yeah. But not day to day.
Q Are you aware of the fact that Red Book lists AWPs for drugs?
A Yes.
Q Are you aware of the fact that Red Book also lists wholesale acquisition prices or direct prices for drugs?
A I was not aware of that. I strictly look at the average wholesale price. Again, that's our point of reference.
Q Are you aware of any prices that are reported in Red Book or other price reporters other than AWP?
A No. Again, that's -- that's our point of reference, so that's what I'm familiar with.
Q Have you ever heard AWP referred to as "ain't what's paid"?
A I'm sorry. I didn't hear what you said.
Q Have you ever heard AWP referred to as "ain't what's paid" as average wholesale price?
A You mean -- no. I -- no. I've never heard of that. It's funny though.

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Q It is, isn't it?
A I've never heard of that, though.
Q Well, do you think there's -- do you think there's any truth to that?
A I have no idea. I don't -- as I've said before, I have no idea what they pay to acquire the drug. Again, because some of our reimbursement programs pay less than AWP, I have to assume that they can acquire the drug for less than AWP. But, again, that's an assumption.
I'm not there to run their business, but I have to assume that they're paying less than AWP. But I've never heard that. It just -- it was just sort of humorous.
Q I'm just about done. If you could give me a couple of minutes, I will -- I should be able to wrap up pretty shortly.
All right. Now, in relation to PBM services, Blue Cross/Blue Shield of Mississippi, has it always had an internal PBM since the time you've been there?
A Since I've been here, we -- we've

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managed our own pharmacy benefits, yes.
Q And you've also mentioned your own contracting with pharmacies, with retail pharmacies?
A As long as I've been at Blue Cross, yes.
Q You've also managed your own contracting with manufacturers?
A I'm not -- I don't know what you mean by that.
Q Do you know whether or not Blue Cross/Blue Shield of Mississippi contracts with manufacturers?
MR. DONNELL: Do you know what part of the agreement that relates to?
MR. MANGI: I'm sorry. Which agreement are you referring to?
MR. DONNELL: The agreement that was provided before this deposition took place.
MR. MANGI: Oh, the list of topics. Yeah, absolutely. The rebates received from manufacturers are directly relevant to amounts paid in

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reimbursements because they lower Blue Cross/Blue Shield of Mississippi's overall costs of reimbursement, their inflow versus outflow.
They're also integral to plaintiff's case and have formed a basis of testimony in every deposition. Indeed there have been individual witnesses provided on this topic by numerous health plans. So defendants will insist on the relevance of this topic.
MR. DONNELL: Okay. I don't find it relevant to the -- any of the deposition subjects that we agreed to, and we'll instruct the witness not to answer.
MR. MANGI: For the record, it's relevant to topics including 1, 2, 4, 8 and 21.
MR. DONNELL: How is it relevant to No. 8? That just caught my eye when

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you -- you were you running through the list. I looked down and looked at 8.

MR. MANGI: Relationships with any PBM --

MR. DONNELL: There is no relationship to any PBM, which he has already testified to. How is that relevant to No. 8?

MR. MANGI: There is a relationship. It's a relationship based on a subsidiary relationship or an internal PBM. And it's the terms of that arrangement and the role of the internal PBM that we're probing.

Look, for the record, if you're insisting that the witness not answer the question, that's certainly within your rights, but we will, then, be forced to move to compel and get another witness on that topic which has already been found relevant in this case.

My questions on it are brief. If

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you'd like him to answer them, that's fine. If not, we can move forward along the lines I've --

MS. FEGAN: I'm not going to take a position one way or another on this, but I just would note for the record that I don't know what you're referring to when you say it's already been found to be relevant. But...

MR. DONNELL: Yeah. We're going to move on anyway.

MR. MANGI: I'm sorry. What was that?

MR. DONNELL: We're going to more forward anyway. We're not going to answer those questions.

MR. MANGI: Is it your position that you will not allow the witness to answer any questions pertaining to rebates -- contracts or rebate arrangements between Blue Cross/Blue Shield of Mississippi and manufacturers?

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MR. DONNELL: That's correct. Because it was not -- it's not listed in those subjects which we agreed to provide a witness for.

MR. MANGI: We obviously disagree on that, but we'll move on.

MR. MANGI: (Continuing.)

Q Turning to specialty pharmacy arrangements. I believe you -- you stated that Blue Cross/Blue Shield of Mississippi reimburses specialty pharmacies at AWP minus a percentage formula; is that correct?

A Yes.

Q Now, if -- is there a particular list of drugs that are delivered to physicians only through specialty pharmacies as opposed to allowing physicians to buy and bill?

A I think currently all of our subscriber contracts allow the physician to continue to supply the drugs themselves without going through the disease-specific pharmacy arrangements. We -- we just encourage their participation in those.

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Q Has Blue Cross/Blue Shield of Mississippi ever considered making the use of specialty pharmacies by physicians to acquire drugs mandatory?

A I haven't been involved in those discussions, so I don't know whether they've taken place or not.

Q Who does have responsibility for specialty pharmacies of Blue Cross/Blue Shield of Mississippi?

A Our director of pharmacy would have that responsibility. But as I said earlier, they work very closely with our -- with our clinical area, our medical management, our medical director. So they would be responsible for the programs, but those discussions would have taken place in that arena, not as much in a contracting capacity.

Q Are you aware of any physician communications to Blue Cross/Blue Shield of Mississippi regarding the desirability of a mandatory specialty pharmacy arrangement?

A Did you say am I aware of any physicians

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sending letters to Blue Cross requesting a mandatory --
Q No. Just discussing the desirability or not of a mandatory arrangement.
A I don't know if they've sent letters to us requesting that or not.
Q Now, in relation to mail order, I believe you mentioned that mail order is not a significant part of Blue Cross/Blue Shield of Mississippi's business; is that correct?
A Right. Not that I'm aware of.
Q Is mail order handled through the internal PBM or through an external PBM?
A Well, I think mail order would be handled through an external vendor. I don't know if they would fall under the definition of PBM. The claims would be paid by our PBM, but we don't have the facilities to actually dispense and mail pharmaceuticals.
So it -- it would be -- it would be an external pharmacy, but the benefits would be managed through our internal staff.

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Q Is there an external vendor with whom Blue Cross/Blue Shield contracts at the present?
A I'm not sure if we're still doing mail order or not.
Q Okay. Are you aware of any past mail order contracts with external vendors?
A I know that we used to offer mail order, but I don't know who the vendor was.
Q Do you know what methodology Blue Cross/Blue Shield of Mississippi employed to reimburse that vendor in relation to mail order scripts?
A I don't.
Q Blue Cross/Blue Shield of Mississippi so chose would it be practical to try and reimburse pharmacies by reference to their individual acquisition costs for drugs.
MS. FEGAN: Could you please repeat the question?
MR. MANGI: Madam Court Reporter, would you mind?
(Previous question read back by the court reporter.)
MS. FEGAN: Objection to form and asked and answered.
MR. MANGI: (Continuing.)
Q You can answer.
A I mean, to say whether it's practical or not, I don't know because we don't know what the acquisition costs are for the drugs currently, and I'm not sure that we have, from a current staffing level, the ability to survey all pharmacies for every individual drug to see what they acquired it for.
So in my own personal opinion, it doesn't sound practical, but I would have to do some evaluation of that process to know for certain.
Q Are you -- are you done with that answer?
A I think so.
Q Certainly, we can agree that it would require an amount of manpower to actually get individual acquisition prices for individual drugs from every pharmacy in the Blue Cross/Blue Shield of Mississippi network, correct? And that would be a -- that would be a substantial undertaking, wouldn't it?
A It would seem to me to be a substantial undertaking, yes.
Q Does the use of AWP as a reimbursement benchmark from which a discount is negotiated provide practical benefits to Blue Cross/Blue Shield of Mississippi, allowing it to avoid the logistical hurdles that would be intending on reimbursing by reference to actual acquisition?
A AWP is a -- is a good point of reference for us for establishing fair and reasonable reimbursement in absence of other points of reference. So, I mean, I'm not sure that I understand what you're asking me in that question.
But as I said, I think it would be impractical to survey every pharmacy for their acquisition costs of every drug that's available, you know, in the United States. So practically speaking, average wholesale price administratively is easier to use, if that gets to the heart of your

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question.
Q That does answer my question, thank you.
MR. MANGI: Thank you, sir.
That's all the questions I have for you at this time.
MS. FEGAN: This is Beth Fegan. I don't have any questions.
MR. ROBBEN: Anyone else?
MR. BATES: This is Gerald Bates. I don't have any questions either.
MR. ROBBEN: Okay. All right. This is Philip Robben. I don't either. I would just like to thank Mr. Brown for coming today and answering our questions.
Counsel for Blue Cross/Blue Shield of Mississippi, Mr. Donnell, has indicated to me that they would like to have the transcript designated highly confidential, so that's taken care of. And we have reserved our right, as the defendants have, to seek additional

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witnesses, and Blue Cross/Blue Shield of Mississippi obviously takes issue with that.
MR. DONNELL: I only take issue to the extent that it goes into the information that was testified to today, to the extent it goes to retail pharmacies -- provider contracting with retail pharmacies, specialty pharmacies, and mail order pharmacies. The rest will not be brought back up.
Any information regarding anything else in the agreement will not be allowed for renotice of deposition without a court order. That's it.
MR. ROBBEN: Okay. Off the record.
(CONCLUSION OF DEPOSITION.)

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CERTIFICATE OF REPORTER

I, AMANDA MAGEE WOOTTON, Court Reporter and Notary Public for the State of Mississippi, do hereby certify that the above and foregoing pages contain a full, true and correct transcript of the proceedings had in the aforenamed case at the time and place indicated, which proceedings were recorded by me to the best of my skill and ability.
I also certify that I placed the witness under oath to tell the truth and that all answers were given under that oath.
I certify that I have no interest, monetary or otherwise, in the outcome of this case.

This the 18th day of March 2005.

AMANDA M. WOOTTON
My Commission Expires:
December 15, 2006